# IMPROVING ACCESS TO MATERNITY CARE:

## OBSTETRIC PROVIDER PARTICIPATION IN MEDICAID


The American College of
Obstetricians and
Gynecologists

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The American College of
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## CONTENTS

# INTRODUCTION

Medicaid has been the principal program financing health care for the nation's poor since 1965. Although often criticized, Medicaid has undoubtedly increased access to health care for this country's indigent population. Since 1984, program expansions on both the federal and state levels, as well as other reforms, have extended Medicaid eligibility and services to new groups of low-income pregnant women and children, resulting in the significant increase of those eligible for Medicaid coverage for prenatal and delivery care (1). Yet, as with other physician specialties, there is an unwillingness on the part of some obstetric providers to participate in the Medicaid program.

Physician providers of maternity care point to four broad categories of concern with regard to participation in the Medicaid program: reimbursement, administration, professional liability, and patient–provider issues. While problems may be apparent in varying degrees to both the Medicaid programs and obstetric providers alike, concern escalates when these problems become barriers to obstetric participation. When access to perinatal services by Medicaid-eligible pregnant women is impeded as a result of low participation by obstetric providers, the full benefits of eligibility expansions and other Medicaid program reforms cannot be realized.

The American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 29,000 obstetrician–gynecologists specializing in the delivery of health care to women, promotes access to health care for all women, including women whose health care is financed by Medicaid. ACOG encourages its members to engage in activities that improve the health status of women and their children, both through the traditional patient–physician relationship and by working within the community at the state and national levels to ensure access to health care for women (2).

The activities ACOG undertakes to foster this goal are numerous. For example, in 1985, the Committee on Health Care for Underserved Women was established to identify problems that underserved women experience with obstetric–gynecologic health care and to develop and implement plans for ACOG involvement with this issue (Appendix A). The committee defines underserved women as those eligible for Medicaid, those who are uninsured and underinsured, adolescents of all socioeconomic levels, and others with identified problems of access. One of the top priorities of the committee is to increase provider participation in public programs such as Medicaid. Among the committee's activities are surveys of ACOG Fellows to determine their activities and opinions regarding obstetric and gynecologic services to indigent women; publication of "Strategies and Options for Improving Access to Maternal Health Care: The Obstetrician–Gynecologist as Advocate," which focuses on the barriers to maternity care and offers suggestions for improved access to care in the obstetrician–gynecologist's own community; and the Underserved Contact Network, composed of ACOG Fellows at the state and local levels who are interested in improving access to health care for women and who have agreed to act as a resource in their respective communities on this issue.

The College has developed a policy statement on the issue of access to women's health care (Appendix B) and frequently publishes articles on this subject in the monthly ACOG *Newsletter*. ACOG is also active in the legislative arena on both the state and federal levels. For example, ACOG frequently presents testimony before the U.S. Congress, comments on proposed federal regulations, and communicates ACOG policies and positions affecting women's health care to government officials. In addition, ACOG conducts an annual

Legislative Workshop, which provides 2 days of intensive training for physicians interested in becoming more politically active in issues pertaining to women's health care.

In 1988, the Health Care Financing Administration (HCFA), the federal agency responsible for administering the Medicaid program, launched the Maternal and Infant Health (MIH) Initiative to devise and implement strategies for reducing the nation's excessive infant mortality and morbidity rates (Appendix C). To specifically address the problems surrounding participation in the Medicaid program for obstetric providers, HCFA, the Bureau of Maternal and Child Health, and ACOG agreed to work cooperatively to develop materials for Medicaid directors and state Medicaid agency staff that provide assistance in their efforts to recruit and retain obstetric providers.

This document reviews the major obstacles to obstetric provider participation in the Medicaid program and describes initiatives states have undertaken to remove these obstacles in the areas of reimbursement, administration, professional liability, patient–provider issues, and provider relations. It also highlights the ways some states are defining and measuring participation. Both definition and measurement are two important factors that must be examined with some degree of specificity in order to determine the effectiveness of any initiatives to increase participation.

Although this document is not intended to be exhaustive, it is hoped that the innovations and initiatives profiled here will encourage similar efforts by other states. State Medicaid programs may wish to explore adapting these approaches. Other interested parties, such as maternal and child health (MCH) programs, state and local health departments, Medicaid fiscal agents, and organizations concerned with provider participation in Medicaid for maternity care, may want additional details on the specific state initiatives outlined in the document. Contacts for each state have been provided at the end of the document for the various initiatives described (Appendix D).

Information for this document was obtained primarily through telephone interviews with state Medicaid program staff between April and August 1990. Individuals from each state Medicaid agency with expertise in maternal and child health were identified by the Maternal and Infant Health Coordinator in each of the 10 HCFA regional offices. They were then contacted by a letter that described the project and ACOG's interest in conducting a telephone interview on the topic of physician participation in Medicaid for maternity care in their states. A list of questions was also enclosed to facilitate the telephone interview (Appendix E).

Questions were chosen to identify barriers to physician participation in Medicaid for maternity services, state initiatives to address these barriers, and the extent to which states were currently measuring physician participation in Medicaid for obstetric care. Interviewees were not requested to return written responses to the questionnaire to ACOG. Of the 51 letters and questionnaires sent, 54 Medicaid agency staff from 41 states were interviewed, 8 states could not be reached for an interview, and 1 state declined to be interviewed (Appendix F). During these interviews it was often suggested that it would be beneficial to speak with other persons in the state. As a result, 24 other persons from 13 states were interviewed by telephone for follow-up information on various state initiatives. These included individuals from state MCH programs, state and local health departments, Medicaid fiscal agents, and hospitals. Selected obstetric providers from the ACOG Fellowship concerned with the issue of physician participation in the Medicaid program for maternity care were consulted and interviewed for this project on an ad hoc basis.

Before turning to the remainder of the document, several points merit discussion. First, it is highly likely that all of the initiatives states are implementing to retain and recruit obstetric providers have not been identified in this document. It is quite possible that other states are implementing similar—perhaps even additional—efforts to increase provider participation in their respective Medicaid programs. However, due to time and resource constraints, as well as gleaning information by telephone, not all efforts may have been identified. It is not intended that some states be overrepresented in the document, nor should the mention of a particular state be interpreted to mean that that state has a more effective Medicaid program in place for recruiting and retaining obstetric providers. Certain state initiatives have been chosen to illustrate particular programs that may be of interest to other states.

Second, at this point there is little evaluation of the effectiveness of the various state initiatives described in the document. Many of these initiatives are new and will require additional time before the effect on provider participation can be determined. The list of state contacts is provided at the end of this document for additional information.

Third, while this document focuses on provider participation in Medicaid, the role of MCH programs deserves mention. State MCH programs, which are funded by both federal and state dollars, are the primary service delivery system of prenatal care for many low-income women. MCH programs are generally administered through state and local health departments and hospital clinics. In addition to providing services, MCH programs have potential for promoting provider participation in Medicaid for maternity care in several ways: they usually employ professional clinical personnel who may be able to communicate and establish personal contact with obstetric providers more easily than the Medicaid program can; they are largely free of the negative perceptions related to billing and administrative concerns that providers may have of the Medicaid program, which allows them to function in a more neutral position to facilitate the relationship between the Medicaid program and providers; and nearly all MCH programs are delivering and paying for prenatal care services through local health departments or other contracted providers, and thus have the ability to adjust policies, procedures, and services to encourage more private physician participation (3).

# IMPROVING ACCESS TO MATERNITY CARE:
## OBSTETRIC PROVIDER PARTICIPATION IN MEDICAID

# PART I: PROVIDER PARTICIPATION IN MEDICAID

## ISSUES

Various studies have examined the issue of physician participation in Medicaid, both across physician specialities and specifically for obstetrics (4–11). This research has also identified many barriers to participation. However, until recently, little federal effort has focused on addressing these barriers identified by providers in order to improve access to maternity services for Medicaid-eligible women. Recognizing the importance of this issue, in 1989 Congress strengthened and expanded a provision requiring states to establish rates for obstetric and pediatric services that are sufficient to enlist enough providers so that these services are available to Medicaid patients at least to the extent they are available to the general population in the same geographic area (12). As part of state Medicaid plan amendments, each year states are required to submit to the Health Care Financing Administration (HCFA) their payment rates for obstetric and pediatric services. They must also demonstrate that Medicaid patients have access to obstetric and pediatric services to at least the same extent that these services are available to the general population in the same geographic area. HCFA issued draft guidelines on the standards states could use to demonstrate adequacy of access in their 1990 state Medicaid plan amendments. By providing data on a county-by-county or other appropriate substate geographic basis, states can choose one of the following to show that:

- At least 50% of obstetric providers are full Medicaid participants or there is full Medicaid participation at the same rate as Blue Shield participation among this group (full participation is defined as accepting all Medicaid patients who present themselves for care)
- The fee-for-service payment rates for obstetric procedures are at least 90% of the average usual, customary, and reasonable (UCR) amount of private insurers
- Equal access can be documented by using other appropriate measures of participation, such as patient surveys or "equal" utilization rates for prenatal visits (13)

However, according to HCFA staff, because of time constraints, the standards for documentation were based on limited research, analysis, and consultation (13). Therefore, guidance for future years on standards documenting access is likely to change as HCFA's knowledge of the techniques to measure access and the availability of data on participation increase (13). At this writing, there has not been sufficient time to analyze the impact of this provision on provider participation.

Provisions in the Federal Maternal and Child Health Program also have the potential to address provider participation concerns with the Medicaid program (3, 14). For example, in order to obtain Title V funds for their maternal and child health (MCH) programs, states must develop comprehensive needs assessments and plans for services to pregnant women. These assessments and plans can be mechanisms for identifying problems in provider availability and potential remedies to address such problems. State MCH programs are asked to work with state-based providers, other agencies, and organizations to develop these needs assessments and plans. Another requirement of state MCH programs is that they must establish a toll-free telephone number so that individuals can access maternity providers participating in the MCH and Medicaid programs. Therefore, MCH programs have a responsibility to identify Medicaid-enrolled providers and assist women in locating them. MCH programs must also develop an interagency agreement with their respective state

Medicaid agency. These agreements can address collaborative interagency efforts to recruit obstetric providers. Finally, state MCH programs must report specific data in their Title V annual reports that include the number of deliveries to Medicaid-eligible women and the number of licensed obstetric providers in the state. Such a requirement could be used as a mechanism to examine the extent to which low-income women are being covered by Medicaid and have access to obstetric providers under Medicaid.

In 34 of the 41 states, staff from state Medicaid agencies interviewed for this project responded that physician participation in Medicaid for maternity services is considered a problem. For some states, such as North Dakota, the problem seemed to have developed recently. Other states, such as Montana, report that most physicians accept Medicaid patients, but limit the number they will accept, which results in access problems. In still other states, the perceptions about participation problems varied depending upon the respondent. For example, in Alaska, the state Division of Public Health reported that "increasing numbers of physicians were dropping out of Medicaid even though reimbursement rates are high compared to other states." However, according to Medicaid staff in Alaska's Department of Provider Enrollment, none of the obstetrician–gynecologists appear to be dropping out of the program.

State Medicaid staff cited low reimbursement, administrative issues, professional liability, and patient problems as the main barriers to obstetric provider participation in Medicaid. For example, in Alabama low participation among obstetric providers was attributed to inadequate reimbursement levels in comparison to private insurance, an excessive amount of paperwork for records and claims submission, potential liability, and poor patient participation in keeping appointments and following directions. The barriers to participation that Medicaid staff identified in this project are consistent with those obtained by the National Governors' Association in the 1988 report "Increasing Provider Participation," which surveyed state Medicaid and MCH programs (15). Likewise, obstetric providers interviewed for this project noted barriers to their participation in Medicaid similar to those cited by Medicaid program staff. Previously, in a survey conducted by ACOG in 1987, obstetrician–gynecologists cited the following concerns regarding Medicaid: low reimbursement; slow payment; denial of eligibility; beliefs that Medicaid patients will sue more, are of a different socioeconomic group than other patients in the practice, are medically too high risk, and are uncooperative; and too much paperwork required to receive payment from Medicaid (6). The results of this survey appear in Appendix G.

It should be noted, however, that in many states access to obstetric providers is a problem for patients who are privately insured as well as for those patients who are financed by Medicaid. This is particularly true in rural areas where no obstetric services may be available and pregnant women, regardless of insurance status, may need to travel long distances to obtain prenatal care.

## DEFINITION AND MEASUREMENT

To measure obstetric provider participation in the Medicaid program, the state agency must precisely define who is a participating provider. In addition, without a "standard" definition of participation, participation rates between states cannot be compared. In collecting data for its 1984 and 1986 editions of "State Medicaid Program Characteristics," HCFA defined a participating provider in Medicaid as one who is enrolled in the program and has billed for services in the past 12 months (16). Several states, including Alaska, Colorado, Iowa, and Texas, indicate that they use this definition for a participating provider. Utah uses the HCFA definition, but varies the length of the reporting period. Other states that use variations of the HCFA definition include Alabama, Arizona, Florida, Mississippi, Nebraska, Pennsylvania, Washington, Wisconsin, and Wyoming. Some states

reported lack of a specific definition for participation, including Idaho, Louisiana, New Jersey, Oregon, South Dakota, Vermont, and West Virginia.

With respect to maternity services, however, all of the above definitions, including the one used by HCFA, are problematic because they do not allow the state Medicaid agency to determine the extent to which an individual provider is participating. It is not clear from any of the definitions if a provider accepts all Medicaid patients, limits those accepted, or places restrictions on the type of patient he or she will accept (eg, high-risk or referral only). Furthermore, confusion exists because the HCFA definition of a participating provider may not be compatible with the 1989 Omnibus Budget Reconciliation Act (OBRA-1989) federal requirement. The HCFA guidance to states for documenting adequacy of access for obstetric services in their state plans, described earlier, defines a participating provider in Medicaid as one who accepts all Medicaid patients who present themselves for care (13).

States differ not only in how they define participation, but in how they measure it. It is important for states to realize that it is difficult, if not impossible, to evaluate the impact on provider participation of any initiatives if a base level measurement of participation is unavailable. In interviews for this project, 26 states reported measuring physician participation in Medicaid as shown in the box.

**MEASUREMENT OF PARTICIPATION**

**States Measuring Participation**

Alaska
Arizona
California
Colorado
Delaware
Florida
Idaho
Indiana
Kentucky
Louisiana
Maryland
Michigan
Missouri
Mississippi
Montana
Nebraska
North Carolina
New Hampshire
New Mexico
Oklahoma
South Carolina
Texas
Vermont
Washington
Wisconsin
Wyoming

**States Not Measuring Participation**

Alabama
Kansas
Nevada
New Jersey
Ohio
Oregon
Pennsylvania
South Dakota
West Virginia

Some states obtain information on the number of physicians participating in Medicaid by analyzing various reports that can be generated from their Medicaid Management Information Systems (MMIS), a large data base containing information obtained from Medicaid claims. For example, in Alabama, Florida, Kansas, Kentucky, and Washington, the state's fiscal agent uses information obtained from the Management and Reporting Subsystem (MARS) of the MMIS to obtain physician participation data. In South Dakota, the Surveillance Utilization Reporting Subsystem (SURS) of the MMIS generates data on physicians participating in the Medicaid program.

Some states plan to collect more information on physician participation in Medicaid. Delaware is implementing a new MMIS which, according to the state's Medicaid director, will have the capacity to generate participation data. In Wyoming, a new MMIS is in operation, and the state hopes to begin using this system to generate reports that will be helpful in measuring physician participation. New Jersey has changed their fiscal agent and the state is optimistic about having an increased capacity for data analysis to measure physician participation. Finally, Colorado has plans to use the SURS of the MMIS to generate physician participation data.

States can also evaluate the extent to which physicians are participating in Medicaid by using state licensure files. For example, New Hampshire, Oklahoma, South Carolina, and Texas can link state physician licensure files with Medicaid provider enrollment files to determine the percentage of participating physicians. However, in using this method it is important to eliminate those physicians who are enrolled in the Medicaid program but not seeing patients, hold a current license but are not seeing patients, or are deceased but have not been purged from the license file (17).

Some states are using direct contact methods to obtain data on obstetric providers participating in the Medicaid program for maternity services. For example, the Bureau of Maternal and Child Health has a contract with seven district health departments in Idaho to conduct a monthly telephone survey to identify physicians providing obstetric services. On a monthly basis, providers are asked if they are accepting Medicaid patients, how many new pregnant Medicaid patients they will accept, and if they have any restrictions for accepting Medicaid patients for maternity care. Similarly, in Louisiana in April 1989, Medicaid staff telephoned enrolled providers to obtain names of those who were accepting Medicaid patients for maternity services. Both of these states were also using the information they obtained to refer pregnant Medicaid patients to obstetric providers.

In using available data, some states generate extensive reports on physicians participating in Medicaid for maternity services. For example, in Washington, the state Medicaid agency is able to obtain data from fiscal years 1986 through the present on both the total number of Medicaid deliveries by county and the total number of obstetric providers by county. This information is then analyzed to determine the average Medicaid deliveries per participating provider by county, as well as percentage changes in participating providers by county per year. Using information obtained from the MMIS, the state can also determine the number of Medicaid women who leave their county of residence for maternity care. In Maryland, there are questions on the birth certificate requesting the source of prenatal care (eg, none, private physician, hospital clinic, or health department clinic) as well as whether the infant's mother was certified for Medicaid. This information can then be linked to the state's MMIS to determine by county the physicians who are providing prenatal and delivery services to Medicaid-eligible women. Indiana matches the Medicaid claims paid to hospitals and private physicians with obstetric CPT codes and specialty codes of providers. This allows the state to determine the number of deliveries to the Medicaid population, the physicians who performed the deliveries, and the hospital in which the deliveries occurred. The Mississippi Medicaid program is currently stratifying physician earnings in the program on a county basis by matching information from the state's MMIS with physician licensure data. In

Iowa and Michigan, the number of physicians in each county who bill Medicaid for specific prenatal and delivery procedures can be identified. In Arizona, the state's new Performance Management Information System (PMIS), effective March 1991, will be able to list and identify the specialty of every provider who receives payment for prenatal care or delivery. Finally, in South Carolina, the state is able to identify the total number of obstetric providers, by name and county, and the level of each provider's participation. Participation is stratified into three levels: less than 25 patients served, 25–100 patients served, and over 100 patients served. In addition, South Carolina is able to identify the exact number of Medicaid-eligible patients to whom a physician has provided prenatal or delivery services.

Reliance on physician participation data obtained from claim payment operating systems presents several problems (15). Since these operating systems are primarily used for claims payment purposes, it may be difficult to generate detailed information on physician participation. For example, states may not be able to obtain information on a physician specialty since that information may not be required for a provider to bill a state's Medicaid program. Some states assign physicians multiple provider numbers depending on the location where the physician renders care; these multiple numbers may make it difficult to identify a physician. Furthermore, physicians practicing in a group may all be assigned the same Medicaid number, thus counting all providers in that group as one provider. However, recent federal legislation requires the Department of Health and Human Services to establish a system to provide a unique identification number for physicians participating in the Medicaid program (18). Some states, such as Delaware, Maryland, and Nebraska, assign both group as well as rendering provider numbers, which assist in identifying the provider who supplied care to the Medicaid patient.

Finally, data that may be helpful to states for evaluating participation may be obtained by surveying physicians directly. For example, in 1987 ACOG surveyed a random sample of its membership on issues related to obstetric and gynecologic services to Medicaid patients. Sixty-three percent of obstetrician–gynecologists who provide obstetric services indicated that they provide obstetric care for Medicaid patients (Appendix G) (6). The study also examined the characteristics of those physicians accepting Medicaid obstetric patients, including physician age, sex, practice type, community size, and the percentage of deliveries that were provided to Medicaid patients. On a state level, ACOG District II, composed of obstetrician–gynecologists in New York, recently conducted a survey in conjunction with the American Academy of Family Physicians, in which physicians were asked about the provision of obstetric care to Medicaid patients. A copy of the survey instrument appears in Appendix H. Some state medical societies have also surveyed their membership on Medicaid participation issues. For example, in Mississippi, the state medical society and Medicaid agency surveyed a random sample of state physicians in order to obtain participation data. While the Mississippi survey included all physician specialties, other medical societies, such as those in Indiana and Virginia, have surveyed only obstetric providers to ascertain the extent of provider participation for maternity services in their respective state Medicaid programs. In addition, several university studies, including those from the states of North Carolina, Washington, and Wyoming, have been able to obtain data on participating providers in the Medicaid program for obstetric services. Although information obtained from physician-reported surveys can be useful in measuring the percentage of physicians participating in the Medicaid program, some have noted that physicians tend to overestimate the portion of their practice devoted to Medicaid patients (19).

## PART II: PARTICIPATION ISSUES AND OPPORTUNITIES

### REIMBURSEMENT

Low reimbursement is frequently cited as a major barrier to physician participation in Medicaid. It is common to hear from obstetric providers that current reimbursement under Medicaid does not allow them to "break even" considering the staff time required to process the additional paperwork often associated with a Medicaid claim, the high obstetric liability premiums per patient, and the extra time spent with a Medicaid patient who is often at risk for a poor pregnancy outcome. Further, although numerous other problems are cited as reasons for nonparticipation and must be addressed, obstetric providers interviewed for this project indicated they or their colleagues would be more willing to consider participating in Medicaid if reimbursement was comparable, or at least reasonably close, to that of private insurers.

Most state Medicaid agencies are aware that low reimbursement is a barrier to participation in the Medicaid program. In a survey completed by the National Governors' Association in 1988, 45.9 % of state Medicaid and MCH agencies responding ranked low fees as the principal reason for the low participation among obstetric providers (15). In the interviews for this project, Medicaid program staff still indicate that they believe inadequate reimbursement is a primary reason obstetric providers choose not to participate in Medicaid. However, as indicated earlier, states are now required to establish reimbursement rates for obstetric and pediatric services that are sufficient to enlist enough providers so that these services are available to Medicaid patients at least to the extent that they are available to the general population in the same geographic area (12).

In recent years, states have altered reimbursement structures under Medicaid in the following ways.

#### Increasing Reimbursement

Increasing the overall amount of reimbursement for obstetric services is the primary strategy states have used to increase physician participation in Medicaid. Many states have linked the importance to reduce infant mortality with increasing obstetric reimbursement rates under Medicaid. In addition, in order to comply with the HCFA adequate payment provisions discussed in the introduction, some states have raised their rates for obstetric services under Medicaid and it is possible that others will do the same.

In spring 1990, ACOG surveyed all states for their obstetric reimbursement rates under Medicaid. A copy of the results of this survey appear in Table 1. Compared with previous rates from a similar ACOG survey performed in 1988, 30 states have increased reimbursement for obstetric procedures during that time period. Some of the increases are significant. For example, California, Idaho, Missouri, and New Hampshire have almost doubled their reimbursement for obstetric global fees; in Michigan, the Medicaid program has increased reimbursement for obstetric services several times during the past 5 years to assist providers with increases in liability costs, reduce infant mortality, and improve access.

## TABLE 1. MEDICAID REIMBURSEMENT FOR OBSTETRIC CARE (SPECIALIST) BY STATE

**MAY 1990**

| STATE | Total OB Global* | Delivery Only Vaginal/Cesarean | Other (High-risk Enhanced Reimbursement) |
|---|---|---|---|
| | $ | | |
| Alabama | 1000.00 | | |
| Alaska | N/A** | N/A** | |
| Arizona | 1,520.00/2,000.00 | | |
| Arkansas | 750.00/856.52 | | |
| California | 1,072.72** | | 1,233.49 (Total: 2,306.21)** |
| Colorado | 900.00/1,313.06 | | |
| Connecticut | 910.00 | | |
| Delaware | N/A | 402.00/546.00** | |
| District of Columbia | N/A | 900.00/950.00** | |
| Florida | 800.00** | | 1,200.00** |
| Georgia | 1,205.00/1,605.00 | | |
| Hawaii | 529.20/868.00** | | YES** |
| Idaho | 1,070.00/1,600.00 | | |
| Illinois | N/A | 550.00/700.00 | |
| Indiana | 769.20/1,076.80** | | YES** |
| Iowa | 717.95/981.76** | | |
| Kansas | 750.00/1,000.00 | | |
| Kentucky | N/A | 650.00/650.00** | |
| Louisiana | N/A | 760.00/1,000.00** | |
| Maine | 863.00 | | |
| Maryland | N/A | 895.00/1,050.00 | YES** |
| Massachusetts | 1,361.00** | | 1,781.00** |
| Michigan | N/A | 373.32/566.40 | 525.53** |
| Minnesota | 561.00/975.70** | | 283.80** |
| Mississippi | N/A | 531.20/637.57** | |
| Missouri | 595.00/--** | --/525.00** | |
| Montana | 741.11/790.27 | | |

*(Table continued on next page)*

## TABLE 1. MEDICAID REIMBURSEMENT FOR OBSTETRIC CARE (SPECIALIST) BY STATE *(continued)*

**MAY 1990**

| STATE | Total OB Global* | Delivery Only Vaginal/Cesarean | Other (High-risk Enhanced Reimbursement) |
|---|---|---|---|
| | $ | | |
| Nebraska | 717.00/1,085.00 | | |
| Nevada | 1,100.00/1,400.00 | | |
| New Hampshire | 1,000.00 | | |
| New Jersey | 468.00/598.00 | | 867.00** |
| New Mexico | 629.46/902.78 | | |
| New York | 1,037.00 | | |
| North Carolina | 925.00/1,025.00 | | |
| North Dakota | N/A | 400.00/480.00** | |
| Ohio | N/A | 400.00/500.00** | |
| Oklahoma | 750.00/875.00 | | |
| Oregon | 899.80/1,059.32** | | 430.00** |
| Pennsylvania | N/A | 312.50/459.00** | |
| Rhode Island | 750.00 | | |
| South Carolina | N/A | 700.00/800.00** | YES** |
| South Dakota | 535.50/887.00 | | |
| Tennessee | 725.00/925.00 | | |
| Texas | N/A | 596.44/785.67** | |
| Utah | 700.00 | | 800.00 |
| Vermont | 850.00/945.00 | | |
| Virginia | 930.00/1,221.00 | | YES** |
| Washington | 850.00/920.59 | | YES** |
| West Virginia | 600.00/913.00** | | |
| Wisconsin | 614.02/793.65** | | |
| Wyoming | 800.00/1,155.00 | | |

*Total obstetric care including antepartum, delivery, and postpartum care. Where two rates are listed, the first is for vaginal delivery and the second is for cesarean delivery.

**See further for explanation.

SOURCE: The American College of Obstetricians and Gynecologists

## EXPLANATION

**Alaska.** Alaska Medicaid reimburses the obstetrician–gynecologist's usual and customary fee. Reimbursement varies by geographic area and provider profile.

**California.** Obstetric services may be billed as a global fee or fee-for-service. Rates indicated are effective as of November 10, 1989. Under California's Comprehensive Perinatal Services Program (CPSP), approved obstetrician–gynecologists may receive additional reimbursement as follows: $50 early entry bonus (when prenatal care is initiated within 16 weeks of LMP); $100 for the tenth antepartum visit. Additional reimbursement is also available on an itemized basis for support services, which include health education, nutrition, and psychosocial services. Support services are reimbursed at an hourly rate for individual and group class intervention ($30.32 individual/$10.00–$12.00 per patient in group); there is a care coordination fee of $76.89 and vitamin/mineral supplements are reimbursed at $36.00. The total reimbursement available for support services is $1,083.49. The total maximum CPSP reimbursement (early entry prenatal care bonus, prenatal care, support services, delivery, and a tenth antepartum visit) is $2,306.21.

**Delaware.** Prenatal care is reimbursed at $14.50 per visit.

**District of Columbia.** Rates indicated are for delivery only. Prenatal and postpartum services are reimbursed at $30 per visit, with the exception of the initial visit, which is reimbursed at $45.

**Florida.** The $800 rate applies equally to uncomplicated vaginal delivery and cesarean delivery with full obstetric care. The $1,200 rate is for high-risk total obstetric care. Rates are expected to increase July 1, 1990 to $1,000/$1,600.

**Hawaii.** Under legislation passed during the 1990 session and awaiting governor's action at this writing, physicians and certified nurse–midwives would be reimbursed for Medicaid deliveries at the private, prevailing rate in the state. This would be a flat rate for either vaginal or cesarean delivery. If approved by the governor, the prevailing reimbursement rates would be instituted on a demonstration basis for 3 years beginning in fiscal year 1990. The intent of the demonstration project is to improve physician and nurse–midwife participation in Medicaid. The State Department of Human Services would be required to evaluate the demonstration project's impact on the number of providers accepting and promoting early pregnancy care for Medicaid patients as well as the project's impact on birth outcomes for Medicaid patients.

**Indiana.** The rate indicated is reimbursed unless the obstetrician–gynecologists's customary charge (established by profile) is less. A Care Coordination Program may be implemented in fall 1990, with additional reimbursement available.

**Iowa.** Rates indicated will increase by 7.44% for the fiscal year beginning July 1, 1990.

**Kentucky.** Rates indicated are for delivery only. Prenatal and postpartum services are reimbursed per visit based on the lower of either the usual and customary fee, the area prevailing charge, or the billed charge.

**Louisiana.** Rates indicated are for delivery only. Prenatal care (limited to 13 visits per pregnancy) and postpartum care (limited to one visit per pregnancy) are reimbursed at $27 per visit, with the exception of the initial visit which is reimbursed at $50.

**Maryland.** Additional reimbursement is available under the Healthy Start Program as follows: $40 for risk assessment; $23 per prenatal care visit with an additional $10 for enriched prenatal care services for a maximum of $33 per visit (there is no maximum limit on the number of prenatal visits the state will reimburse ); and $23 for postpartum services.

**Massachusetts.** Rates indicated are for Standard Total Global ($1,361) and Enhanced Total Global ($1,781). Enhanced Total Global is defined as the direct provision and supervision of case management, maternal evaluation, and obstetric risk assessment and monitoring, in addition to vaginal or cesarean delivery, all routine prenatal visits, and one postpartum visit.

**Michigan.** Rates indicated are for delivery only. The $525.53 rate is for high-risk prenatal care services.

**Minnesota.** Rates will be increased to $645.15/$1,122.06 effective July 1, 1990. The enhanced reimbursement rate for high-risk prenatal care will also be increased on July 1, 1990 to $327.37.

**Mississippi.** Prenatal care is reimbursed on a per visit basis.

**Missouri.** Missouri Medicaid reimburses a global rate for vaginal delivery only. This rate is expected to increase to $1,050 on July 1, 1990 at which time a global rate for cesarean delivery may be instituted. The $525 rate in the second column is for cesarean delivery only. Prenatal care is reimbursed on a package basis for a total of $300.

**New Jersey.** Obstetrician–gynecologists approved to participate in the HealthStart Program are reimbursed at the $867 rate.

**North Dakota.** Prenatal care (limited to 9 visits) is reimbursed at $11 per visit for a total of $99.

**Ohio.** Prenatal care is reimbursed at $20.71 per visit.

**Oregon.** Under Oregon's Medicaid Maternity Case Management Program, established in April 1988, obstetrician–gynecologists may receive additional reimbursement for specific, individual services as follows: Initial Needs Assessment—$20; Ongoing, Full-Service Case Management—$60; High-Risk Case Management—$100; Nutrition Counseling—$40; and Home Services—$60 (must include home assessment, training and education; a maximum of four visits may be billed individually, in combination, or when all services have been provided). Either of the case management services may be billed and reimbursed on a "partial services" basis if the patient initiates but does not follow through with treatment, or if the patient becomes high risk during the latter part of her pregnancy. Or, the obstetrician–gynecologist may bill a global fee for Total Maternity Case Management at a rate of $430.

**Pennsylvania.** Rates indicated are for delivery only. Pennsylvania Medicaid reimburses obstetrician–gynecologists for an unlimited number of medically necessary office visits for prenatal care at a rate of $18 per visit.

**South Carolina.** Rates indicated are for delivery only. Risk assessment is required for all Medicaid-eligible pregnant women and is conducted during the initial prenatal visit. The initial visit is reimbursed at $50 and risk assessment at $20. Prenatal and postpartum services are reimbursed at $20. Additional reimbursement for enhanced services is available under the Healthy Mothers and Healthy Futures program.

**Texas.** Obstetrician–gynecologists are reimbursed on a reasonable charge basis using the Medicare pricing profiles. Rates indicated represent an average payment. Texas Medicaid does not reimburse a global rate for total obstetric care. Prenatal care is reimbursed on a per visit basis at a maximum rate of $16 for a normal pregnancy and $19.20 for a high-risk pregnancy.

**Virginia.** Under Virginia's Baby Care Program, high-risk services are reimbursed at additional rates.

**Washington.** Effective August 1, 1989, additional reimbursement is available under Washington's First Steps Program. An Initial Prenatal Assessment is reimbursed at $50. This includes medical history, physical examination, and identification of risk factors. The Initial Prenatal Assessment may be billed once per patient and within 120 days of the assessment. Obstetrician–gynecologists may bill for the management of high-risk pregnancies as specified; physicians providing documentation of high-risk indicators not specified may also bill for the additional reimbursement. High-risk management may be billed in addition to routine antepartum care and/or total obstetric care *only* if a high-risk condition exists during the trimester of care. Antepartum care must be billed within 120 days of the end of each trimester. The reimbursement rates for high-risk management are as follows: first trimester—$75; second trimester—$75; third trimester—$150. There is also a fee for management of labor under the First Steps Program of $100 that may be billed when you are the physician who has managed prenatal care but cannot perform the delivery due to unanticipated medical complications. In this instance, the patient must be in active labor and admitted to a hospital or certified birthing facility when the referral to the specialist is made.

**West Virginia.** Effective July 1, 1990, West Virginia Medicaid will discontinue its Total Obstetric Global reimbursement codes.

**Wisconsin.** Rates indicated will increase in July 1990.

Alaska, one of the two states that does not use a fixed fee schedule, is seeking legislative approval and funding of a new profile of each obstetric provider's usual, customary, and prevailing (UCP) charges. The Alaska UCP profiles have not been updated since 1986. Therefore, providers who entered the state in 1987 have not been profiled and are reimbursed the amount billed; those providers who entered the state before 1987 are reimbursed at the UCP, which is usually a lower rate.

In Hawaii, a bill was enacted on July 9, 1990 that reimburses Medicaid deliveries for physicians and nurse–midwives at prevailing state insurance rates. Hawaii is the first state to adopt this approach. The increase in rates is part of a 3-year demonstration project intended to increase physician participation in Medicaid (20).

Medicaid reimbursement rates tend to be lower than third-party rates, and research indicates that the differential between payments from public programs and charges to private patients is a more important determinant of participation than the absolute level of public payment (4). By using data from local third-party insurance organizations, states can compare their rates to private insurers' obstetric rates. In Idaho, for example, a Department of Health and Welfare work group compiled data from a number of different sources, including current fees from obstetrician–gynecologists in Idaho communities; average fees from a survey of obstetrician–gynecologists, family physicians, and general practitioners conducted by the Washington, Alaska, Montana, and Idaho (WAMI) Rural Health Research Center at the University of Washington; average billings to the Idaho State employees' private insurance pool; and average billings to Medicaid. The data base constructed from all of these sources was used to develop the state's new increased Medicaid reimbursement rates for obstetric services. However, such data from third-party insurance organizations may be difficult, if not impossible, to obtain.

Unfortunately, little data are available on the effect of increased reimbursement on obstetric provider participation in the Medicaid program. Recently, New York completed a study showing that the number of private physicians participating in the provision of Medicaid obstetric services in the first 6 months of 1988 increased 9.18% over the number participating in the first 6 months of 1987 (21). Researchers at the University of Southern Maine are currently studying the effects that increased fees have on patient access to health care and physician participation in Maine's Medicaid program. Additionally, the state of Maryland plans a study to examine the effect of increased reimbursement on obstetric provider participation rates. Some states interviewed report positive comments, albeit anecdotal, from their obstetric providers about fee increases, including California, Colorado, Florida, Idaho, Kentucky, Montana, New Hampshire, New York, and Pennsylvania. Other states, such as Delaware, Nebraska, and South Dakota, have indicated that they are unsure how providers are reacting to the fee increases. In North Carolina, it is thought that fee increases have only stabilized existing physician participation rates for maternity care. Finally, the Michigan Medicaid Agency reports that even with fee increases, the Medicaid program's reimbursement level continues to be lower than that of private insurance and problems of participation persist.

### Restructuring Fees

Some states reimburse obstetric care under Medicaid on a global basis, covering prenatal care, delivery, and postpartum care in a single fee. Others, including Delaware, Kentucky, Mississippi, South Carolina, and Texas, reimburse separately for the prenatal, delivery, and postpartum components of maternity care. In all states, however, delivery and prenatal visits are also reimbursable on a per-visit basis; but this reimbursement, when added together, is likely to be lower than the global fee, if there is one. Texas discontinued its global rate in order to encourage early entry into prenatal care. With that change, maternity clinics that provide prenatal care but not delivery services are now reimbursed. South Carolina discontinued global reimbursement in favor of reimbursement for individual services because the latter method was thought to be more cost effective. In 1988, Kentucky rejected the global billing approach because of administrative complexity and because of fluctuations in the eligibility status of Medicaid patients (15). Continuous eligibility is now a federal mandate; therefore, concerns regarding the fluctuation in eligibility of the patient are no longer applicable.

Some states have also established alternate fee structures. For example, a separate reimbursement of $500 for prenatal care has been established in Missouri. The Obstetric Subcommittee to the Physicians' Task Force, an advisory committee to Missouri Medicaid, recognized it was necessary to pay separately for prenatal care to reduce inadequate prenatal care, as well as to increase provider satisfaction. To receive this global prenatal care

reimbursement, however, the obstetric provider must render at least five prenatal care visits. Kansas reimburses on a package rate per trimester for prenatal care. Although this state has a global rate for total obstetric care, a provider must bill for prenatal care using the trimester package if a pregnant Medicaid patient received any prenatal care from another Medicaid provider. According to the state's fiscal agent, some providers in Kansas are frustrated with this requirement. For example, if an obstetric provider bills globally, unaware that the patient was originally seen by a different provider for prenatal care, the claim will be denied; the provider must then resubmit the claim, billing separately per trimester for prenatal care.

When states do not use the global method to reimburse for maternity care under Medicaid, it is important that the link between prenatal care, delivery, and postpartum care be maintained. This is particularly true for the Medicaid patient who may be at high risk and for whom information from prenatal care may be especially important for increasing the chance of a healthy birth outcome. As discussed above, Missouri allows charges for maternity care to be separated into the prenatal care package and delivery and postpartum care. However, when the individual payments for the prenatal care package, vaginal delivery, and postpartum care are combined, the total equals that of the global reimbursement. The state decided to allow providers either billing option in order to accommodate those obstetrician–gynecologists and family practitioners who provide prenatal care and intend to, but ultimately do not, perform the delivery. It must be emphasized, however, that obstetric providers are strongly encouraged to provide the full range of services and bill the global rate.

Both California and New Hampshire have eliminated the differential in global obstetric reimbursement between global vaginal and cesarean delivery. In California, as no significant fee increases for obstetric services are planned for the future, the state intends to increase reimbursement for high-risk maternity care rather than providing higher reimbursement for cesarean deliveries. Both Montana and Oregon have brought the fees for vaginal and cesarean delivery closer together. In Oregon, this move was made so that additional monies could be allocated for family planning services.

### Providing Rural Incentives

In many rural areas of the country, all pregnant women, regardless of the type of insurance they have, experience problems with access to care for maternity services. To encourage physicians to provide care in rural settings, some states have looked at establishing differential Medicaid payments for providers rendering maternity care in rural and urban areas. West Virginia, for example, in July 1990 discontinued global fees and set two levels of payment for the same prenatal service based on whether the service was provided in a rural or urban area. Due to provider dissatisfaction, however, the differential was discontinued as of October 11, 1990. Montana rejected rural and urban differentials in part because of objections raised by urban providers who render care to pregnant women residing in rural areas. Instead, the state opted to increase global rates for maternity care for all providers.

### Expanding the Reimbursable Scope of Services

Some states now reimburse obstetric providers additional amounts for specific maternity visits and services. For example, an initial prenatal assessment that includes specific services such as a medical history, physical examination, and identification of risk factors may be reimbursed at a higher level than subsequent prenatal care visits. Wyoming increased the fee for an initial office visit for maternity care to $70; South Carolina has established a $100 fee for an enhanced initial obstetric office visit which includes a Women, Infants, and Children (WIC) referral and the initial obstetric exam. According to the state Medicaid agency, obstetrician–gynecologists are pleased with this arrangement and there has been an increase in the use of this procedure code in Medicaid billing. In California, obstetric providers who

participate in California's Comprehensive Perinatal Services Program (CPSP) receive a $50 bonus when prenatal care is begun within the first trimester. In addition, CPSP providers can also receive an additional $100 at the 10th prenatal care visit.

Additional payment to obstetric providers is also available in some states, such as Idaho, Maryland, Ohio, and West Virginia, for performing a prenatal risk assessment. West Virginia uses the Problem-Oriented Perinatal Risk Assessment System (POPRAS III) to identify high-risk, Medicaid-eligible pregnant women. The primary care provider will be reimbursed $100 by Medicaid if parts 1A and 1B of the POPRAS are completed during the first 15 weeks of pregnancy, or $50 if completion occurs during the second or third trimester of care.

In Maryland's Healthy Start Program, obstetric providers can be reimbursed by Medicaid for providing enriched maternity services, including prenatal and postpartum counseling; health education; nutrition education for pregnant and postpartum women; care coordination; and referral to the local health department for additional services, such as high-risk nutrition services and case management services. Similar services are covered by Oregon's Enhanced Maternity Management Program. Providers receive an additional $10 per prenatal care visit for rendering these enriched services. It should be noted that the Maryland program is particularly well suited to the private provider. A similar program is also in place in South Carolina through the state's Healthy Mothers–Healthy Futures Program, in which the private provider can easily participate. Under this program, obstetric providers receive enhanced reimbursement from Medicaid for providing maternity care that incorporates health education, referral to community support services, and follow-up on missed appointments. These additional services must be documented, albeit briefly, in a patient's record. South Carolina is using funds donated from Mead Johnson and Ross Laboratories to fund the state's share of these enhanced payments.

Additional payments are also available for providing high-risk care to Medicaid-eligible pregnant women in Florida, Michigan, Ohio, Oregon, and Washington. In Michigan, pregnancies are considered high risk if the patient is at risk for medical complications, if she is in need of psychologic or nutritional counseling, or if she is under age 17 or over age 35.

In Oklahoma, the state allows obstetric providers to bill one ultrasound per pregnancy separately from the global fee. A second ultrasound is allowed for medical necessity. In addition, Oklahoma Medicaid is working with independent laboratories to devise a program whereby obstetric providers can use a wider range of laboratories for prenatal tests and bill Medicaid for these procedures. In West Virginia, the state will reimburse obstetric providers for services that Medicaid-eligible pregnant women receive for medical conditions unrelated to prenatal care. According to the state, providers are pleased with this.

**Experimenting with New Payment Methodologies**

Maine is currently implementing the Resource Based Relative Value Scale (RBRVS) as a method to determine provider reimbursement under Medicaid. The RBRVS is a method of reimbursement that assigns values to physicians' services based on the work required to perform a service. Such a system is currently being implemented for the Medicare program. The Michigan Medicaid agency has run a simulation using state Medicaid data to determine how the RBRVS would affect physician reimbursement in that state. Two other state Medicaid agencies, Alabama and Missouri, have also suggested looking at the RBRVS for reimbursement under Medicaid.

**Reimbursement Issues for Other Providers**

Low reimbursement for other provider specialties may affect access to obstetric care for Medicaid-eligible women. For example, in Arkansas, fees for anesthesiologists were raised,

in part because Medicaid-eligible patients were experiencing difficulty in obtaining surgical services such as tubal ligations.

### Disproportionate Share Payments

HCFA will recognize an incentive payment for high-volume providers participating in the Medicaid program, including private obstetric providers. This high-volume incentive parallels the concept of "disproportionate share" used for reimbursing hospitals. Until recently, Missouri provided incentive payments to high-volume obstetric providers, including private physicians, who participate in the state's Medicaid program. However, when the state increased its reimbursement rates for obstetric providers, these incentive payments were discontinued.

## ADMINISTRATIVE ISSUES

The Medicaid bureaucracy and its complex administrative procedures are often cited as a barrier to physician participation in Medicaid. States must process 90% of "clean claims," ie, those that are error free, within 30 days. Yet, even with the above provision, slow payment for services by Medicaid is a significant problem for obstetric providers, and it is unclear whether the factors that lead to slow payment are being addressed to the satisfaction of providers. Often, slow Medicaid payment can be attributed to claims that are pending or ultimately rejected because of errors made by providers in completing the claim form. Slow payment may also result because claims for specific services, such as a cesarean delivery or a tubal ligation sterilization procedure, are singled out for special manual review by the Medicaid agency or fiscal agent. It must be emphasized that slow payment can be especially infuriating to providers who bill globally—these providers may need to wait almost a year to receive payment for obstetric care rendered. Others have suggested that slow or delayed payment is a calculated state strategy to manage the lack of state revenues to fund Medicaid services.

Bureaucratic red tape is a chief complaint of obstetric providers. Examples of red tape include the inability to contact provider relations for assistance, unexplained claim rejections, the auditing of providers for fraud and abuse, the necessary attachments and documentation required to receive payment, and the complexity of the Medicaid claim form. In interviews with obstetric providers, some commented that state Medicaid agencies neither identify clearly nor announce in a timely manner payment procedures for obstetric services. The need to obtain prior authorization for certain procedures, such as hysterectomy and sterilization, was also an objection cited by obstetric providers. In addition, obstetric providers and their staff often express criticism over the complexity of Medicaid claim form. It is unclear, from interviews with both Medicaid program staff and obstetric providers, whether billing manuals and training are understandable to office staff who usually complete the Medicaid claim form.

While some of the state Medicaid programs interviewed believe that obstetric claims processing is a problem for provider participation in Medicaid, others, including Kentucky's, maintain that it is not a problem. In New Hampshire, claims processing was one of the topics addressed by the state's Medicaid Provider Participation Task Force, formed in 1989. When this issue was confronted by the task force, the original contention was that billing for providers under Medicaid was a problem. However, upon further discussion, the problems seemed to be the result of misconceptions. For example, physicians in New Hampshire believed erroneously that the state agency used its own procedure codes and a special nonuniversal claim form. The special procedure codes and claim forms, however, were eliminated in 1985, when the state switched fiscal agents. Thus, according to one member of the task force, "The billing is pretty much like it is for other third-party payers. It is unclear how much of a problem claims processing really is—and how much is perceived." In North

Carolina, problems with claims processing may also be more of a perceived problem, with some of the negative perceptions on the part of physicians carried over from the 1970s, before the state had initiated automated claims processing. Such misperceptions indicate that obstetric providers may be unaware of the strides made to improve claims processing.

State Medicaid program staff often expressed the opinion in interviews that problems with claims processing, when they do occur, can be attributed to the provider or provider's office staff. Most states were quick to stress they use the HCFA 1500 form, which is similar to claim forms used by private insurance companies. In addition, most states offer training and billing seminars for provider staff on how to complete the claim form. Medicaid staff commented that often there is little continuity in office staff and there is little effort on the provider's part to ensure training for new staff. In addition, Medicaid staff expressed concern over whether important billing information and changes in the Medicaid program that are addressed to the physician were being passed on to billing staff. When further queried on specific reasons why claims are denied, the chief problem was thought to be that the provider or office staff were "simply not filling out the claim form correctly." Errors can include incorrect entry of the patient's eligibility or provider number, failure to submit attachments required for payment, and the use of incorrect or obsolete CPT codes; but it is also possible that not all state Medicaid programs are using the most current CPT codes. Another common problem cited by Medicaid staff is that the provider has not verified the eligibility of the patient, but providers may be experiencing difficulty confirming eligibility because states do not have systems in place that easily access this information.

From information obtained in interviews with both Medicaid program staff and obstetric providers, three points merit discussion. First, although many states allow providers to bill using the HCFA 1500 claim form—a form identical to the AMA universal claim form—many provider billing staffs do not routinely complete insurance claims, but leave this responsibility to the patient. Many private offices use a "superbill" form that lists the medical procedure codes along with the appropriate diagnosis codes for each patient's visit. The superbill is accepted by all major third-party payers. In most offices, after each visit the patient receives a superbill that she simply attaches to a claim form and submits directly to her private insurance company.

Second, it is not clear whether complex rules with respect to billing are being communicated clearly to obstetric providers or to their billing staff. Nor are the reasons for this lack of communication clear. Strategies for alleviating this problem are discussed in the sections "Billing Seminars and Training" and "Provider Liaison."

Finally, from interviews with obstetric providers and their staff, situations involving claims that need to be submitted repeatedly in order to receive payment generate an enormous amount of frustration. Further, this frustration over just one claim, combined with difficulty in contacting provider relations, can tarnish a provider's perception of the Medicaid program. More importantly, in the view of some obstetric providers, if administrative problems associated with claims processing could be solved, they would be more willing to participate in the Medicaid program. Thus, to encourage and increase physician participation, state Medicaid agencies may want to consider implementing some of the initiatives described in this section to make their program easier to use. In order to alleviate some of the problems associated with claims processing, states have developed the following initiatives.

### Electronic Claims Processing

This allows providers to bill either tape-to-tape, usually through an outside billing service, or through their personal computer using a specific software program and a modem. Electronic billing has been implemented, for example, in Idaho, Kansas, Kentucky, Mississippi, New Hampshire, New York, Oregon and Wisconsin.

Electronic billing has advantages for both the obstetric provider and the Medicaid agency. For the obstetric provider, payment on a clean claim submitted electronically is quicker than those submitted on paper. In addition, many of the provider errors, such as wrong provider numbers, substitution of alpha for numeric characters, and incorrect CPT codes, can be eliminated. Moreover, should a claim need to be resubmitted, the provider's billing clerk can easily make the necessary changes directly on the computer screen and resubmit the claim via modem, eliminating the need to fill out another claim form. From the Medicaid agency and fiscal agent perspective, electronic billing is also beneficial because many of the front-end errors associated with data entry are reduced. In addition, electronic billing is cost effective for Medicaid programs because fewer personnel are needed to perform data entry functions associated with paper claims. In some states, such as Idaho, Kansas, New Hampshire, New York, and Wisconsin, the fiscal agent will furnish free software to the obstetric provider's office, set up the billing system for the provider, and supply personal attention until the provider's staff is comfortable with the new system of billing. These states are encouraging providers to bill electronically and are vigorously marketing this option through the use of bulletins, messages on the bottoms of remittance notices, provider training seminars, and visits to individual provider offices. In Idaho and New Hampshire, the state's fiscal agent distributes office supplies, such as pencils, pens, and oversized plastic paper clips to encourage providers to switch to electronic billing. Kentucky invites software vendors to set up exhibits at annual provider workshops conducted in the state.

In order to allow providers to bill electronically for obstetric procedures requiring attachments, the Missouri Medicaid program is considering the use of unused fields on the HCFA 1500 billing form. Kansas is also in the process of developing a window screen that providers can use for attachments when billing electronically. States that have instituted electronic billing are receiving a positive response from obstetric providers and their billing staffs.

There are some disadvantages to electronic billing. For example, if a provider's office lacks the necessary computer hardware, billing via a personal computer and modem is not an option. However, providers can still use an outside billing company in order to submit claims tape-to-tape. Also, sterilization claims must still be submitted on paper because of the federal requirements regarding the consent form.

**Provider Assistance Telephone Lines**

Some states have "help lines" to answer provider inquiries about billing. These telephone lines are usually administered through the Medicaid agency or the fiscal agent, and, in some instances, by both. In most states, the provider assistance lines are not limited specific providers. However, in California there is a hot line devoted to answering questions about maternity claims. Trained obstetric billing specialists answer obstetric billing questions, summarize claims in process, and assist in follow-up with any billing problems. Interviews with both obstetric providers and Medi-Cal indicate a positive response. The Colorado Medicaid program offers a Medicaid communications service through its fiscal agent that answers billing questions for all Medicaid providers, including obstetrician–gynecologists. Several provider representatives are specifically trained regarding prenatal and obstetric services and are available to answer these questions. This provider assistance line responds quickly which has greatly added to its success. In Pennsylvania, special staff are dedicated to handle telephone inquiries from providers enrolled in the Medicaid Healthy Beginnings Plus Program, which provides payment for care coordination and comprehensive medical and nonmedical maternity services.

While provider assistance lines are generally helpful to office staff, a major complaint cited by billing clerks is that these telephone lines are often busy. In addition, it is not uncommon for a provider's staff to be kept on hold for a lengthy period of time before they are able to

speak with a provider relations representative. Moreover, not all provider assistance lines are toll free, a point which further irritates provider staff if they are placed hold for a substantial period of time. In interviews with Medicaid staff, it was acknowledged that these assistance lines are frequently busy and that office staff may be placed on hold until a provider relations representative is available. In some states, such as Pennsylvania, the provider assistance lines are severely understaffed. Mississippi has added more telephone lines to help remedy this problem and is monitoring how long it takes for a provider's call to be answered. Kansas has also increased the number of telephone lines available for provider questions.

**Billing Seminars and Training**

Most states have training sessions to help provider staff learn how to fill out Medicaid claim forms. These training sessions are usually conducted either in a large group setting or on an individual basis in the provider's office. Interviews with providers and their staff indicate such training sessions are quite helpful. However, special efforts are needed to keep up with the turnover of providers' office staff and impress upon providers the need to ensure training for new staff. One state, Pennsylvania, eliminated the field representatives who conducted provider training and currently there is no technical assistance available to providers or their staffs for billing inquiries. The state is in the process of reinstating positions because of complaints from providers.

To improve their relationships with providers with respect to billing issues, some states have enhanced their provider assistance activities. For example, in Arkansas the state Medicaid Agency is investigating the use of small hands-on training sessions for provider billing staff, rather than the larger group lecture format used in previous years. The state has found face-to-face contact with each physician specialty beneficial in reducing provider inquiries and increasing provider satisfaction. To better assist providers, California's fiscal intermediary is developing technical assistance materials for office staff training. These materials are targeted for providers in small group and solo practices in geographic areas defined as medically underserved. Materials will include a concise desktop reference, which will provide quick reference to the most commonly asked billing and claim form problems. A videotaped orientation to the fiscal intermediary system is being distributed to providers, and two videotapes are being developed that address the most frequently identified billing problems. These videotapes are used in conjunction with visits to provider offices by the fiscal intermediary staff. In Michigan, provider relations representatives will visit the office if in the provider's neighborhood to maintain communication and determine if problems are occurring with billing.

Some states, such as California, New York, and Montana, are targeting those provider offices with high billing error rates and following up with necessary instruction. In New York, the state's fiscal agent also generates a weekly report of payment summaries and county denial rates by provider type. Those physicians with a high rate of claim denials are contacted by an area fiscal agent representative to determine and alleviate problems in claims processing.

**Provider Liaison**

Some state Medicaid agencies have established specific staff liaisons to obstetric providers. Colorado, for example, has established the position of a clinical coordinator in the Department of Physician Services who is the designated liaison to the obstetric and gynecologic community. In Arizona, where all care for the indigent is managed through the Arizona Health Care Cost Containment System (AHCCCS), all 14 prepaid health care plans must have a maternal health coordinator whose function is to manage the maternity program. One of the AHCCCS plans interviewed has increased the responsibilities of this position in response to the problems of obstetric providers. The Maternal Health Coordinator for this

plan, a registered nurse, communicates policies and procedures to obstetric providers, authorizes medical procedures (as opposed to staff with no medical training), reviews medical claims and standards of care, and assists the provider relations department on field visits to obstetric providers (22). The South Carolina Medicaid agency has a specific program manager for obstetrics and gynecology. In addition to recruiting activities, this program manager contacts new providers to see if they are experiencing any problems with Medicaid, travels to physician offices statewide, meets with office staff as often as possible, handles problem claims, helps set policies that affect obstetric providers, develops the physician billing manual, and acts as a professional liaison to the South Carolina Medical Association. In Maryland, nurse consultants, in addition to their recruiting activities, also act as ombudsmen for obstetric providers. In Mississippi, the state recently placed a physician on the provider relations staff at the fiscal agent to answer any medical questions from providers regarding claims. According to interviews with Medicaid staff in these states, obstetric providers are appreciative and pleased with these liaison activities.

### Eligibility Verification

According to interviews with state Medicaid staff, one of the most frequent reasons that a Medicaid claim is rejected is that the patient is ineligible. Some states have instituted eligibility hot lines so providers can confirm a patient's eligibility. In Maryland, providers are encouraged to use the toll-free Eligibility Verification System (EVS); they are also encouraged to read the handbook describing the system and the various messages generated by the EVS. Kansas also has a voice-response eligibility hot line. Comparable systems have been in place in Oregon since 1986. It should be noted, however, that not all eligibility hot lines are toll free.

In New York, providers can access to the Electronic Medicaid Eligibility Verification System (EMEVS), which is a small terminal placed in a provider's office that allows them to access Medicaid patient information. By entering the recipient's Medicaid identification number, the provider can verify ID numbers, eligibility, and approved services. Kansas is also planning to develop such a system that, in addition to verifying eligibility, would also check on the status of claims.

### Improving the Provider Manual

A common problem with respect to billing Medicaid noted by provider office staff is that the provider manuals are too difficult to understand. To address this concern, Montana is attempting to make its Medicaid Provider Manual easier to use. One example of an easy-to-understand manual is the one distributed by the Maryland Medicaid program for obstetric providers participating in the state's Healthy Start Program. This manual, particularly suited for a physician in private practice, describes the Healthy Start Program, provides sample billing forms, and includes a listing of health departments and essential Medicaid telephone numbers.

### Separate Obstetric Medicaid Bulletins

In interviews with obstetric provider office staff, there were complaints that information about maternity care is usually "lost" in lengthy Medicaid bulletins sent to the provider. South Carolina, for example, has attempted to remedy this problem by providing separate obstetric bulletins, when possible (Appendix I).

### Elimination of Sequential Edits

Some providers have mentioned sequential editing as a problem they encounter when submitting Medicaid claims for reimbursement. With sequential editing, a provider's claim is

removed from the system each time an error is encountered. Thus, in encountering the first error, the claim is sent back, the provider must complete another claim form, and resubmit the claim. If another error is found when the claim is reprocessed by the Medicaid agency, it is again returned another time for correction to the provider. Of course, resubmission is both costly and time consuming, as well as enormously frustrating for the provider or office staff. Several states have developed methods to limit or eliminate sequential edits. New Hampshire recognizes two errors prior to the claim being sent back to the provider. In Maryland and Wisconsin, systems are in place that will detect all errors at one time on Medicaid claims. Currently, in Florida the fiscal agent will continue to process a claim even though it contains an error, provided the error does not materially affect the claim.

### Claims Correction Strategies

Some states have attempted to eliminate the need for providers to resubmit claims in the case of correctable errors. In Kansas and New Hampshire, a Claims Correction Form (CCF) has been developed. The CCF is sent to the provider, and lists all correctable errors found on the claim. Upon receipt of the CCF, the provider simply supplies the appropriate information and returns the form. According to the state's fiscal agent, these forms are met favorably by the provider community. The Maryland Medicaid program has developed a similar form, the Turn Around Document (TAD), for claims under review. The TAD informs the provider of the reason(s) a particular claim is being reviewed and asks the provider to supply any necessary information directly on the document. The provider has 45 days to return the document; once received by the Medicaid agency, the corrections are entered into the system and the claim is processed. When the state first instituted the TAD in 1989, the number of pending claims was reduced from 485,000 to 80,000 in 3 months. According to an interview with Maryland Medicaid, the TAD is received favorably by providers.

In Utah, the Medicaid agency has obtained approval from the HCFA regional office to make corrections on a claim form over the telephone, provided that Medicaid staff documents with whom in the provider's office they spoke and the changes that were made on the claim form.

### Sterilization Claims

In interviews with obstetric providers and Medicaid staff alike, it is clear that sterilization claims pose special problems. Both providers and Medicaid program staff are frustrated by the federally mandated coverage requirements that the patient be at least 21 years old, and that 30 days elapse between the time the consent form is signed by the patient and the procedure is performed. Some states, however, are attempting to make the claims process for sterilization operate more smoothly. In South Carolina, for example, there is one person in the Medicaid agency whose primary responsibility is to process sterilization claims. Obstetric providers are encouraged to send all sterilization claims directly to this person, rather than the fiscal agent. In California, with assistance from ACOG District IX and the California Medical Association, the standard sterilization form was redesigned in order to make it easier to use. In Kansas, changes were made in the state's claims processing system so that only the first surgeon performing a sterilization need submit a consent form; other providers assisting with the surgery are not required to include the consent form with their claims. In only one state interviewed, North Carolina, does the processing of sterilization claims for both the provider and the Medicaid agency not seem to be a problem. Apparently, there is good communication between providers, the state Medicaid agency, and the local health departments over this issue.

### Third-Party Liability

In conjunction with OBRA-1989 recommendations, in March 1990 New York instituted Third Party Liability ("pay and chase") (18). All service claims by providers for eligible pregnant

women that would have been previously denied because they were covered by third-party insurance are now paid by the New York Medicaid program. The state, rather than the provider, then seeks reimbursement from the third-party payer. According to New York, the initial response from the provider community has been favorable since it has sped up claim processing and payment.

### Committees and Task Forces on Claims Processing

Some states have initiated committees and task forces to examine the problems associated with claims processing under Medicaid. In Alabama, for example, the Claims Processing Committee of the Physicians Task Force (composed of Medicaid staff and physicians) made recommendations to eliminate the 180-day limit on filing claims after a service is provided, use simpler language for all provider notices and bulletins, and repeat important provider notices in subsequent provider bulletins. In New Hampshire, the Task Force on Increasing Provider Participation in the Medicaid program advocated that efforts should be made to simplify and streamline billing procedures, including allowing providers to use a superbill, eliminating the sequential editing system for notifying providers of errors, and continuing to process claims that contain an error if the error does not materially affect the claim. In Missouri, the Medicaid Physicians' Task Force made recommendations to lighten the administrative burden on physician providers. These included reformatting the Missouri Medicaid Provider Bulletin to make it more easily understood by providers, eliminating attachments to the standard billing form when possible, and using a toll-free line to confirm patient eligibility. The latter two recommendations have been implemented and the state is receiving good reactions from physicians.

## PROFESSIONAL LIABILITY

Concerns over professional liability are another reason obstetric providers do not participate in Medicaid for maternity services. This problem is of concern to all obstetric providers, however, not just Medicaid providers. In 1990, ACOG surveyed its membership and found that 12.2% of obstetrician–gynecologists surveyed had stopped practicing obstetrics as a result of malpractice concerns (23). In addition, 24.2% of obstetrician–gynecologists had decreased the level of high-risk obstetric care that they provide. Moreover, 46.3% of obstetrician–gynecologists surveyed devote 10% or less of their time caring for high-risk obstetric patients. The implications of this statistic may be particularly troubling for Medicaid programs, considering the high-risk status of many of their patients. These trends are consistent with similar findings from other studies (24).

Family physicians have also discontinued obstetric practice due to liability problems (25,26). In rural areas, family physicians are critical to the provision of obstetric services. One survey found that 35% of family physicians and general practitioners surveyed in Washington state had discontinued obstetric practice after January 1, 1986 because of the fear of a malpractice suit (26).

In 1988, the Institute of Medicine (IOM) convened a committee of experts to examine the impact of professional liability in obstetrics. In its report *Medical Professional Liability and the Delivery of Obstetrical Care*, the panel concluded that a crisis exists in the area of medical professional liability (27). The committee also analyzed the impact of medical professional liability on the provision of obstetric care to poor women and women served by Medicaid and concluded that "the effects of professional liability concerns in obstetrics are being disproportionately experienced by poor women and women whose obstetric care is financed by Medicaid or provided by Community and Migrant Health Centers" (27).

The cost of liability insurance premiums has risen dramatically for providers of obstetric care in the past decade. Although the cost paid by obstetrician–gynecologists show substantial

regional variations, respondents to the ACOG survey paid an average of $38,138 for professional liability insurance in 1989 (23). Family physicians who do obstetrics also have experienced rapidly increasing liability premiums. Insurance premiums for family physicians practicing obstetrics are significantly higher than costs for family physicians not practicing obstetrics (25,27). According to the American Academy of Family Physicians, the average premium in 1985 for a $1 million (per incident)/$3 million (aggregate) malpractice coverage with obstetrics including cesarean delivery was $9,447, compared with $5,300 for a practice without obstetrics (28). In 1986 those figures had risen to $11,389 with obstetrics and $6,037 without obstetrics. In some areas of the country, the differential is even greater. The Institute of Medicine study reported that in Washington and Alabama, family physicians pay almost three times as much for coverage that includes obstetrics as for coverage that does not (27).

The increase in professional liability insurance premiums compounds physicians' long-standing concern about low Medicaid reimbursement for services (6, 27). Liability concerns about Medicaid are expressed by physicians in three ways. First, reimbursement under Medicaid is not sufficient to cover the cost of malpractice premiums. Second, with increasing malpractice costs, providers must devote more time to private patients in order to meet expenses (27). Third, an obstetric provider may be unwilling to care for low-income women, including Medicaid-eligible women, because of fear of suit. Many physicians believe that low-income patients are more likely to initiate suit than private-pay patients. For example, 41% of obstetrician–gynecologists surveyed in Washington state believed that Medicaid patients are more likely to file a malpractice suit compared to their other patients (26). Furthermore, physicians may perceive that reducing care to Medicaid and other low-income women is a way to decrease the number of high-risk patients, as these populations are thought to be at a greater risk for developing complications with their pregnancies. Some have suggested that all patients whose care is paid for by Medicaid are less likely to initiate suit than are middle-class or privately insured patients (29). With respect to obstetric patients, data indicate that women whose maternity care is financed by Medicaid file suit at approximately the same rate as their representation in the patient population (30, 31).

Medicaid agencies are concerned about of these perceptions and aware of the problem as revealed in the interviews for this project and previous documents (15). For example, in California, the Medi-Cal agency has requested guidance from HCFA on ways to alleviate the professional liability problem. In New Mexico, a Blue Ribbon Task Force composed of representatives from the medical, legal, and insurance industries, as well as legislators and consumers, has been established at the University of New Mexico. After studying the issue of medical professional liability and its impact on access to obstetric services, the task force will make recommendations to the legislature on this issue. Partial funding for this project will come from Medicaid funds. At the University of Washington, the Obstetrical Access Project, a 3-year project funded by the Robert Wood Johnson Foundation, is working to improve access to obstetric care for low-income women. The project's activities include researching malpractice questions, presenting research findings on malpractice risks and the propensity of Medicaid women to file claims, sharing ways with obstetric providers to reduce malpractice risks, and suggesting ways to increase patient compliance.

Currently there are two broad categories of state initiatives enacted into law by state legislatures that may be of interest to Medicaid agencies in addressing the problem of professional liability as it relates to obstetrics. It should be noted that these initiatives are intended to ease the entire obstetric liability situation and are not targeted only for those physicians participating in Medicaid. The Institute of Medicine has made several recommendations for easing the liability situation, including the following approaches (27).

### Liability Premium Subsidies for Obstetric Providers

Under this approach, the state subsidizes the liability insurance premiums to attract obstetric providers to underserved areas or encourage their participation in public programs financing maternity care, such as Medicaid. States have established such funds on a one-time-only basis or have continued the fund over several years. Premium subsidies may be made available to select providers, to all providers in a certain geographic area, or on a per-delivery basis for any obstetric provider who willingly agrees to provide services to certain categories of pregnant women. Typically, subsidies are calculated according to the percentage formula of total patient case load that is Medicaid or indigent (32). States using this approach include Arizona, Hawaii, Louisiana, Michigan, North Carolina, Texas, and Washington. Hawaii, the first state to adopt this approach in 1986, continues to fund this initiative each year because of its success in increasing access to obstetric care. In North Carolina, the state legislature increased funding for their Rural Obstetrical Care Incentive Program from $240,000 to $540,000 under a 1990 legislative proposal that is part of the state's infant mortality package. This program provides subsidies for liability premiums to physicians and certified nurse–midwives who agree to provide prenatal and delivery services in medically underserved counties.

### State-Funded Indemnity for Obstetric Providers

Under this approach, the state finances a physician's medical liability claim in certain circumstances, for example, when the physician has agreed to provide free or minimally compensated health care services under contract with a city or county. The physician is indemnified against suit by the appropriate government entity, and liability is shifted from the health care provider to the government (32). States using this approach include Louisiana, Missouri, Texas, and West Virginia. In Missouri, malpractice suits brought against covered physicians are defended by the Attorney General's Office. The Texas law differs from the Missouri law in two key ways. First, the state does not assume responsibility for defending suits or for the entire amount of liability, but instead agrees to pay the first $100,000 of any liability payment in obstetric cases. Second, if the physician provides at least 10% charity care, then the state makes the payment for all patients, not just those whose care is paid for by Medicaid. Louisiana has passed a bill modeled after this Texas legislation.

Montgomery County, Maryland, is tackling the liability problem by indemnifying their obstetric providers. Through Project Deliver, the county health department hires obstetrician–gynecologists as temporary part-time employees (rather than contracting for their services) to deliver health department patients and indemnifies them while delivering these patients. In addition, the county assumes liability for these patients, both paying awards and defending claims. The program has greatly increased access for delivery services to county health department patients. It has been so successful that it was the recent recipient of a 1990 Innovation in State and Local Government Award sponsored by the Ford Foundation and the John F. Kennedy School of Government at Harvard University which, among other criteria, looks at the degree to which a particular initiative can be replicated in other areas.

## PATIENT–PROVIDER ISSUES

Another set of reasons cited by providers for not participating in Medicaid is related to patient problems and negative impressions of Medicaid patients. These issues generally fall into categories concerning patient eligibility for Medicaid coverage, patient risk, and patient responsibility. Physicians have often been reluctant to begin providing maternity care to women on Medicaid because of difficulty in determining eligibility and fluctuations in eligibility status throughout the pregnancy. Some obstetric providers perceive the Medicaid-eligible woman to have greater potential for developing a high-risk pregnancy and therefore

exclude Medicaid and other low-income women from their practice as a way of avoiding high-risk patients. Obstetric providers also are concerned about patient responsibility for following prenatal care recommendations, breaking or missing appointments, bringing and leaving children unattended in the waiting room, and leaving the waiting room in disarray. Furthermore, some private obstetric providers believe that if they accept too many Medicaid patients, their private patients may go elsewhere.

Interviews with state Medicaid staff bring another perspective to these issues. Medicaid patients may have differing needs, both medically and socially, from privately insured patients, such as a lack of transportation or child care, or different perceptions of the value and timing of prenatal care and frequency of appointments. There may be language and other cultural differences between the patient and physician. Some Medicaid staff, when interviewed, were concerned that obstetric providers have the perception that Medicaid patients are the responsibility of the health department or public sector only.

Medicaid directors and staff also raised the question of how racial or social prejudice affect an obstetric provider's decision to accept Medicaid patients. Some Medicaid staff expressed the impression that Medicaid patients would rather receive care in public health settings because of poor acceptance in the private obstetric provider's office. Little exists in the literature regarding this issue, but it is an area that deserves further investigation. In May 1990, South Dakota surveyed pregnant women covered under the expanded Medicaid eligibility program to determine if they had any difficulty in obtaining maternity care and if Medicaid eligibility affected the kind of care they received. This survey did not identify a problem in either of these areas. A follow-up survey of the same type is planned to determine if the increasing numbers of pregnant women eligible for Medicaid coverage have access problems because of provider attitudes. To alleviate some of the problems providers voice concerning Medicaid patients, states are implementing the following initiatives.

### Eligibility

Several legislative reforms in eligibility have increased the number of pregnant women eligible for Medicaid. For example, states are now required to provide Medicaid coverage to pregnant women with incomes up to 133% of the federal poverty level. In addition, states may also elect to cover pregnant women with incomes up to 185% of the federal poverty level and qualify for federal matching funds to accomplish these expansions (Appendix J). To expand Medicaid coverage for pregnant women above 185% of the federal poverty level, states must use their own dollars. California, for example, uses additional state funds to pay for services for pregnant women and infants up to 1 year of age with incomes up to 200% of federal poverty level. States are also now required to provide continuous eligibility for pregnant women, which assures Medicaid benefits throughout the pregnancy and postpartum period regardless of changes in family income. In addition, states may choose to implement presumptive eligibility, whereby pregnant women can be granted immediate eligibility with final eligibility determined within 45 days (Appendix J).

Obstetric providers have generally responded well to these eligibility reforms, and have been advocates for them in an organizational capacity on both the national and state levels. However, it may take some time before providers learn about and trust changes in eligibility determination systems. For example, some obstetric providers in Florida expressed concern as to how many women deemed eligible in the presumptive period actually met the eligibility requirements. Furthermore, providers must have a simple way to verify a patient's eligibility before they will trust the eligibility expansions. Increased information and one-to-one education can be helpful in these cases. In Maryland, for example, Medicaid staff explain to providers that with the eligibility expansions, the Medicaid patient may not be the usual "welfare" patient of the past.

While the eligibility reforms have allowed more low-income women to receive Medicaid coverage, states legislators, as well as the National Governors' Association, have expressed concern about the financial costs of such eligibility mandates. In addition, some obstetric providers have noted that care must be taken when financing these eligibility expansions. These providers are particularly concerned about the impact of reducing MCH budgets in order to fund Medicaid eligibility expansions and increased reimbursement. In some communities, if there are not enough obstetric providers or if few private providers are willing to accept Medicaid patients, women may have to seek care in public health settings, which may already be overstrained. While public health clinics in many states can bill Medicaid for services provided, they often require money for start-up expenses, or services not covered by Medicaid.

**Enriched Benefits and Case Management/Care Coordination**

In recent years, some states have also elected to enhance the services available to pregnant women through enriched benefits and case management/care coordination (Appendix K). Enriched benefits may include such services as risk assessment, nutrition counseling, health education, psychosocial counseling, home visiting, and transportation. These benefits are intended to address the nonmedical needs of the pregnant patient. State programs vary as to who can provide such enriched services and private providers, although eligible, may not meet the certification requirements to render such services. In Maryland, however, private providers can easily render enriched services, such as health education, and receive an enhanced reimbursement from Medicaid if these services are documented. The state Medicaid agency provides a special checklist that the provider can easily complete for documentation. The patient who needs more extensive services can be referred to the health department. A new program of support services in Michigan provides the preventive services of psychosocial and nutrition counseling, health education, and transportation services for medical care. The program is designed to assist both the recipient and the physician. In New York, the Prenatal Care Assistance Program (PCAP) offers a comprehensive care and case coordination for all eligible pregnant women. This includes, but is not limited to medical, nutritional, psychosocial, educational services.

Case management and care coordination, terms which are often used interchangeably, have also been implemented in some states so that a pregnant woman's medical and nonmedical care are better linked. Care coordination can include confronting the obstacle of patients breaking appointments. States vary as to who can provide this service, and often it is the health department that supplies the care coordinator. Private practitioners may not have the necessary number of staff or staff with the appropriate training to be certified as case managers. An example of an extensive case management program is Alabama's Maternity Waiver Program for women who reside in certain counties. These Medicaid-eligible women receive a comprehensive, coordinated, and case-managed system of obstetric care. The two main components of the waiver are case management and a freedom-of-choice restriction. Restricting patients' choice of provider enables Medicaid to establish a primary care provider network that ensures women comprehensive and coordinated maternity care according to individual risk status through one provider. If the primary care provider is an institution or health department, private providers may provide the medical component of care through a subcontract. Preliminary data have shown that the Alabama Maternity Waiver Program has been successful in reducing low–birth-weight and neonatal intensive care days.

North Carolina, through the Baby Love program, has also implemented care coordination. Maternity care coordinators focus on the total needs of the patient and facilitate obtaining those services for the pregnant woman. Those women receiving maternity care coordination, as compared to those women not receiving the service, had a substantially increased number of prenatal visits, greater WIC participation, more live births, and fewer low–birth-weight and very-low-birth-weight babies. In addition, based upon an initial assessment, those women

receiving maternity care coordination had been deemed at greater risk for a poor pregnancy outcome than those not receiving the service. In conversations with North Carolina Medicaid staff, care coordination was cited as the glue holding the enriched services together.

### Prenatal Care Media Campaigns and Outreach

Some states have used prenatal care media campaigns as a way to and provide information to all pregnant women on the importance of prenatal care. For example, Utah has implemented an extensive public information outreach campaign. Begun in March 1987, it is a cooperative effort between the Utah Department of Health, KUTV (an NBC affiliate), the Utah Medical Association, Blue Cross and Blue Shield, and the March of Dimes. The campaign includes public service announcements, 5-minute news programs, television program specials, coupon booklets, inserts in the newspaper, bus boards, program guides, and a hot line. According to the Department of Public Health, physicians have responded positively to this campaign, and that all women, not just those eligible for Medicaid, are encouraged to obtain early prenatal care. The entire campaign has been sold to other states. A similar campaign has been initiated in North Carolina and several other areas (33).

### Provision of Child Care Services

Some Medicaid-eligible women may not be able to keep prenatal care appointments because of child care responsibilities. As part of the state's First Steps Maternity Program, Washington now assists pregnant women to obtain child care during prenatal visits. Patients are screened either by a case manager or a support services provider to determine their need for child care. The screening includes questions to determine the patient's ability to pay for child care and the availability of other resources. If a patient is eligible for the child care services, payment is authorized by giving the patient an appropriate number of time-limited child care vouchers. The Medicaid patient has her prenatal care provider sign the voucher at the time of her appointment, then gives it to the child care provider who submits it for reimbursement. Payment is made to the child care provider within 2 weeks of the time the voucher is received by the state. This initiative has the potential to address provider concerns both with unattended children in the waiting room and women needing to miss prenatal care appointments because of child care responsibilities.

### High-Risk Patients

States have initiated measures specifically designed to target high-risk pregnant women covered by Medicaid. For example, in both Idaho and Maryland, providers are asked to complete risk assessment forms for Medicaid clients. If the pregnant woman faces an increased likelihood of a high-risk pregnancy, the physician can request enhanced services from the health department for her. In South Carolina, there is a specific program for high-risk pregnant women called the High Risk Channeling Project (HRCP). Implemented in 1986, the project seeks to reduce infant mortality and morbidity and improve the health status of pregnant women covered by Medicaid. Each pregnant woman is assessed for risk factors at her first prenatal visit. If she is found to have one or more of the factors listed on the risk assessment form (Appendix L), she is entered into the HRCP. HRCP services include prenatal care by an obstetrician–gynecologist, social worker evaluation and follow-up, case management, nutrition services, and delivery at a hospital with specified equipment and personnel.

### Substance Abuse During Pregnancy

To address the growing problem of substance abuse during pregnancy, South Carolina reimburses specific drug treatment services. Covered services include counseling, an intensive outpatient program, crisis management, and targeted case management. In addition, the

South Carolina Medicaid agency has developed several other strategies to address perinatal substance abuse, including advocating alcohol and drug treatment center policies that avoid discrimination against pregnant women; involvement in a statewide, blinded prevalence study of drug use in pregnant women; and adding maternal alcohol and drug use and infant exposure to alcohol or other drugs as risk factors requiring participation in the Medicaid High Risk Channeling Project for pregnant women. The Medicaid agency is also involved in a cooperative effort with the South Carolina Commission on Alcohol and Drug Abuse (SCCADA) and the Department of Health and Environmental Control (DHEC) to provide statewide training for medical personnel, alcohol and drug treatment personnel, and ancillary service staff who work with pregnant women and infants. The South Carolina Medicaid agency has assisted in the development of an interagency policy that advocates appropriate care for pregnant women and infants affected by substance abuse, as well as alternatives to punitive solutions. The state is addressing the perinatal substance abuse problem in the context of strategies to reduce infant mortality in counties that have the greatest share of infant mortality in the state. Finally, the state is involved in various grants, including those funded by the U.S. Office of Substance Abuse Prevention (OSAP), which target women and children affected by substance abuse.

## PROVIDER RELATIONS

Some states have adopted strategies to improve the relationship between obstetric providers and the Medicaid agency. Such efforts include a variety of direct communication programs to recruit and retain obstetric providers in the Medicaid program. Other states have explored various service delivery options for the private obstetric provider participating in Medicaid. These strategies are discussed below.

### Direct Recruiting

One mechanism for increasing provider participation in Medicaid is to actively recruit obstetric providers either directly in a face-to-face effort or through provider relations activities. These efforts are generally initiated by the state Medicaid agency, the MCH program, and occasionally the Medicaid fiscal agent. In most states the fiscal agent does not take an active role in provider recruitment, although representatives of the fiscal agent may be involved in provider relations activities through the use of telephone help lines and provider training seminars. Any provider recruitment functions could be specified in the contract between the Medicaid agency and the fiscal agent, with the cost for these activities reflected in the amount of the contract between the state Medicaid agency and the fiscal agent.

In Maryland, a team of seven nurse consultants, jointly funded by the state's MCH and Medicaid programs, have implemented a recruiting campaign to increase obstetric participation in Medicaid. These nurses identify obstetric providers by county and directly encourage them to participate in Medicaid. The nurse consultants also urge private obstetric providers, regardless of whether the provider accepts Medicaid, to refer any uninsured pregnant patients to the local health department for eligibility determination. On a typical visit to a provider's office, a nurse consultant will speak with the provider (and in most cases, the provider's office staff) about any changes regarding eligibility for pregnant women and the importance of the role of the provider in reducing infant mortality. They explain the enriched services available for pregnant women in Maryland through state's Healthy Start Program, and educate the provider and staff about billing for maternity services under the Medicaid program. The nurses are available at any time to answer questions or solve problems that the provider or office staff may have with Medicaid.

To identify obstetric provider offices to visit, nurse consultants review the names of providers who have billed Medicaid for obstetric procedures in the past year. They also obtain the

names of new obstetrician–gynecologists through announcements in the newspaper and, in some instances, through the telephone book. The nurse consultants also give presentations on the Healthy Start Program to community groups and physicians during hospital staff meetings.

The nurse consultants interviewed were generally positive about the recruitment efforts. They feel that obstetric providers are appreciative of the personal touch from Medicaid, particularly concerning eligibility and billing problems. However, it is not unusual for them to encounter resistance from providers about participating in Medicaid. Much of the resistance, they believe, is based on attitudes and perceptions that these providers have about Medicaid patient. Another obstacle the nurses face is gaining the cooperation of the physician's front office staff, who act as gatekeepers. The nurse consultants have found that alerting the office staff to the need for physician participation in Medicaid and the recent changes that have occurred within Maryland's Medicaid program regarding maternity care will often open the gate.

According to the nurse consultant who directs these recruiting efforts, the measure of success varies according to the presenting obstacles. In the areas of the state where resistance to participation is greatest, just negotiating an appointment with the front office staff to gain access to the physician is considered an achievement. The nurse consultants feel that positive strides are made when an office agrees to provide literature or referral information on Medicaid eligibility to uninsured women. When a previously nonparticipating physician agrees to continue services for a patient who becomes Medicaid eligible, the nurses' efforts have been worthwhile. However, they see increasing the number of physicians accepting new referrals as the greatest priority. Face-to-face encounters provide the opportunity for the nurse to establish a working relationship with the private provider and build confidence in the program. The nurse consultants stress that in order for recruitment efforts to be successful, it is important to be sensitive to the working relationships established in the community, such as those between the local health department, the hospital, and community obstetrician–gynecologists. Thus, in the Maryland program each nurse consultant is assigned specific counties where the local political climate is generally well known on a day-to-day basis. Finally, in looking toward the future, the nurse consultants express a strong desire to work more closely with the organized provider community, such as ACOG, on both the state and national levels. Plans for a formal evaluation of the Maryland program are currently being discussed.

Washington is also involved in an intense effort to directly recruit obstetric providers by marketing the state Medicaid agency's First Steps Program. The First Steps Program resulted from the Maternity Care Access Act of 1989, which among its provisions expanded eligibility for pregnant women, increased Medicaid reimbursement for maternity care, and instituted case management for high-risk pregnant women. The First Steps marketing plan uses a six-pronged approach to attract providers. It enlists new physician providers in Medicaid; encourages enrolled obstetric providers to accept more Medicaid patients; increases the state's Medicaid agency's awareness of providers who may be discontinuing obstetrics; improves customer service to obstetric providers; recognizes providers who have consistently provided care to Medicaid patients; and educates health professionals about Medicaid. To accomplish these goals, the marketing plan has enlisted the support of physicians through the state medical society and physician specialty groups, such as the Washington State Obstetrical Association, the Washington ACOG section, and the Washington Association of Family Physicians.

An effort to directly recruit obstetric providers on a local level is currently being implemented in San Diego, California through the Perinatal Access Project, a joint effort between ACOG District IX and the James Irvine Foundation. In order to improve access to prenatal care for low-income women in the county, the project seeks to increase the number of physicians in private practice who provide obstetric care to women whose care is paid for by Medi-Cal and

to establish a telephone referral service to link low-income women to appropriate prenatal care. When the project first began, a complete list was compiled of obstetrician–gynecologists and family practice physicians known to perform deliveries at area hospitals. This list consisted of 241 names of which 59 (25%) were known to be accepting Medi-Cal patients. After this list was compiled, a letter (Appendix M) was mailed to each of the physicians outlining the project objectives, accompanied by a fact sheet identifying recent changes in the public and private sector programs that affect access to perinatal care for low-income women. The mailing also contained a provider information sheet, which the provider was asked to complete and return indicating willingness to participate in the program (Appendix M). Follow-up information regarding the project, Medi-Cal, and related programs within the state's perinatal network, was made available to physicians through the project coordinator. As a result of this recruitment effort, as of October 1, 1990, an additional 34 physicians agreed to accept Medi-Cal patients. This represented an increase from 25% to 38% of those originally identified as potential providers. Fifty-three physicians agreed to participate in the telephone referral service. This number includes 19 physicians who were known to be accepting Medi-Cal patients and the 34 physicians recruited under the project. Seven physicians who were Medi-Cal providers declined to participate in the telephone referral service, indicating they did not wish to have an additional source of Medi-Cal referrals.

The success of the recruitment effort in San Diego can be partially attributed to the support of the San Diego Gynecological Society, which suggested that each of their members accept at least one new Medi-Cal obstetric patient from the referral service each month. In addition, the need for such a program in the community was strongly advocated by some of the county's obstetrician–gynecologists. Another selling point for recruitment was to provide options regarding both the number and the medical risk level of new Medi-Cal patients. Physicians participating in the referral service may choose the number of new Medi-Cal patients they wish to have referred to them each month. In addition, the physician advisory board to the project has developed a triage system to prevent the referral of high-risk patients to a particular provider, should that provider request so. Finally, Medi-Cal patients are referred to eligibility workers prior to their first office visit in order to expedite the Medi-Cal eligibility determination.

In Texas, the contract between the state Medicaid agency and the National Heritage Insurance Company (NHIC), the state's insuring agent and entity that underwrites the Texas Medicaid program, specifies that NHIC must promote provider participation in sufficient numbers and specialties throughout Texas to make services readily available to eligible recipients. According to NHIC, their goal is "to ensure that the state's Medicaid clients have adequate access to healthcare providers" (34). NHIC is required to pay particular attention to physician specialties with low participation rates and to underserved areas of Texas. In addition, NHIC must have a plan for mobilizing staff and resources to remedy any significant reduction in the number of eligible providers. To accomplish recruitment and retainment of providers, the NHIC provider relation staff contacts providers who are not enrolled in the Medicaid program and encourages their participation.

NHIC makes presentations at meetings held by medical professional associations, county medical societies, residency programs, and hospital staff meetings. These presentations provide an opportunity to foster support for the goals of the Medicaid program, as well as dispel any negative impressions that providers may have. In addition, these meetings expose nonparticipating providers to information they might not hear otherwise. NHIC also establishes personal contact, through their provider representatives, with providers who have recently enrolled in the program. These direct contacts are initiated to facilitate interaction with the Medicaid program and establish rapport with the provider representative. Finally, information regarding policy and procedural changes in the Medicaid program is made available to providers by NHIC through regularly scheduled workshops and publications. Suggestions from the provider community for improvements in

notifying providers of changes in the Medicaid program, as well as implementing these changes, are welcomed and frequently incorporated (34).

Direct recruiting of obstetric providers, in conjunction with provider relations activities, is also is occurring within the South Carolina Medicaid program. Using a list obtained from the South Carolina Medical Association, all licensed obstetrician–gynecologists are visited by the state's ob/gyn program manager. This individual travels to physician offices throughout the state and explains the Medicaid program, along with any recent changes that have occurred in the program. The program manager answers questions and tries to correct any misperceptions obstetric providers may have. To date, almost every obstetrician–gynecologist has received a visit. Follow-up visits are made to new providers about 6–8 weeks after they have enrolled in the program to determine if they are experiencing any problems. In addition, the program manager and staff work at achieving a solution to problems identified by all providers, new or old. Recruitment efforts have been successful with at least 20 new obstetrician–gynecologists agreeing to participate in the program over the past year.

In New Hampshire, the fiscal agent coordinator within the Medicaid agency (the staff member who is responsible for liaison with the fiscal agent) visits physicians who have expressed interest in participating in the state's Medicaid program. Such visits are described as successful in recruiting providers. For example, following a presentation to a group of private obstetrician–gynecologists at a local hospital, all but one enrolled in the Medicaid program.

As another direct recruitment strategy to attract providers into their program, some state Medicaid agencies mail information to obstetric providers explaining changes in the program. For example, in Missouri a letter (Appendix N) was sent to physicians encouraging them to participate in the state's Medicaid program. Those already participating were asked to increase the number of Medicaid patients they accept and to encourage other new providers in their community to accept Medicaid patients in an effort to reduce the state's infant mortality rate. The letter also cited the recent increases in the state's reimbursement rates for obstetric providers. In Louisiana, the Governor sent a personal letter to obstetric providers in the state urging them to participate in Medicaid (Appendix O). In New York, the state Medicaid agency and ACOG District II sent a joint letter to the ACOG membership in New York encouraging them to participate in the program (Appendix P). Finally, in California, a brochure titled "Improvement in Perinatal Care" has been developed and has been endorsed by ACOG District IX, the American Academy of Pediatrics, the California Medical Association, and the March of Dimes. This brochure outlines the recent improvements made in Medi-Cal's obstetric program, such as increased reimbursement and billing assistance, and encourages participation in the Comprehensive Perinatal Services Program (CPSP), the state Medicaid program of enhanced and care coordination services.

### Crisis Response

State Medicaid agency staff indicate that crisis intervention efforts are generally initiated for one of two reasons: either a provider is threatening to drop out of Medicaid because of dissatisfaction with the program, or efforts are needed to recruit providers in an area where there is a severe shortage of Medicaid obstetric providers. In West Virginia, which has a general shortage of obstetric providers, when a provider is known to be considering dropping out of Medicaid, both the State Health Department Maternal and Child Health Program and Medicaid staff make direct contact to encourage the provider to continue in the program. The state has had success with such face-to-face intervention to the degree that if the provider has already dropped out of the Medicaid program, they will usually reenroll. Similarly, in Nebraska Medicaid staff make the effort to contact an obstetric provider to rectify a problem before the physician drops out of the program.

An example of an effort to recruit providers in an area experiencing a severe shortage occurred in 1988 in Arkansas. An intensive provider recruitment campaign was undertaken in Sebastian and Polk Counties in which Medicaid staff met with each private obstetric provider. The recruitment effort was successful and seven providers were persuaded to accept Medicaid patients. Part of this success can be attributed to obstetric providers being given the name of a professional staff contact at the Medicaid agency and instructed to send their completed claims directly to this person. The contact person reviewed each claim and checked for any errors. If the claim was error free, it was forwarded for processing. However, if the claim contained any errors, the professional staff contact notified the obstetric provider by telephone and explained the errors made in completing the claim form. Then, if the obstetric provider agreed that the errors on the claim could be corrected by the Medicaid staff person, a copy of the corrected claim was sent to the provider and the corrected original was forwarded for processing. Both Medicaid staff and obstetric providers have been pleased with this arrangement because it has eliminated the need for obstetric providers to resubmit claims and has provided feedback to providers on the specific errors that are being made when completing the Medicaid claim form.

### Service Delivery Options

When considering strategies for increasing physician participation in Medicaid, states must address physician concerns regarding service delivery. Some obstetric providers, for example, will not accept Medicaid patients for maternity services in their private office but would be willing to care for these patients in another setting, such as a clinic, at the local hospital, or health department. Other obstetric providers indicate that they would be willing to accept some Medicaid patients for maternity care, but are concerned about whether they will be able to limit the number of Medicaid patients in their practice should they begin accepting them.

In interviews with Medicaid staff, the idea of voluntary participation in Medicaid on a "fair share" basis was often expressed as one strategy for increasing participation. For example, one Medicaid director thought a possible strategy for implementing fair share would be for obstetric providers in a specific area, such as a county, to divide the number of deliveries to Medicaid patients among the area physicians able to supply prenatal care or perform deliveries. According to this director, obstetric organizations on both the local and national levels should play an active role in organizing these arrangements.

Some states and local communities have implemented various initiatives to address some of the provider concerns, increase access to maternity care for Medicaid-eligible women, and encourage participation through fair share. Although many of these arrangements have arisen because of crisis situations in which Medicaid-eligible pregnant women were unable to obtain prenatal or delivery care in their local community, they could be used before a crisis occurs. Also, the established relationships in the community, such as those between the hospital, health department, and obstetric providers, should be taken into consideration when planning service delivery strategies that effect the private provider.

In order to respond to crisis situations, some local communities have established prenatal clinics for Medicaid patients in area hospitals, staffed on a rotating basis by private providers. For example, in Carson City, Nevada, because no obstetrician–gynecologists were accepting Medicaid patients, Medicaid-eligible pregnant women had to travel nearly 45 miles for prenatal visits, but were delivering on a drop-in basis at the local hospital. While the local obstetrician–gynecologists had previously accepted Medicaid patients, low reimbursement had caused them to discontinue this practice. One local obstetrician–gynecologist emphasized that the group would have continued to accept Medicaid patients for obstetric care if the reimbursement had been sufficient to cover even office overhead costs; instead, the group was losing money.

To alleviate this crisis, the local hospital and the Carson City obstetrician–gynecologists established a prenatal clinic at the hospital for Medicaid-eligible women. The clinic is open 2 hours a week with all obstetrician–gynecologists providing prenatal care and delivery on a rotating basis; the hospital provides office space, nursing and support staff, prenatal laboratory work, and ultrasound services. Interviews with both hospital staff and one of the obstetrician–gynecologists indicate that the arrangement seems to be working. The clinic allows the hospital nursing staff to maintain their obstetric skills, and the increased volume for certain procedures, such as sonograms, generates additional revenue. There are also advantages for the obstetrician–gynecologists. For example, continuity of care now exists between a woman's prenatal care and delivery. A patient's prenatal care records are available to the delivering physician, providing information about any complications a woman might have experienced. The hospital absorbs the expenses associated with office space and nursing staff. With recent increases in Medicaid reimbursement for pregnancy-related services, the obstetrician–gynecologists participating in this clinic can feel that they at least meet their costs. Finally, the hospital and Medicaid agency assist the obstetrician–gynecologists with payment problems. Although the hospital, physicians, and women receiving care under this clinic arrangement are pleased, there is a shortage of space. The clinic is currently using vacant hospital rooms on the labor and delivery floor. However, the hospital is undergoing reconstruction and it is hoped that the clinic can be transferred to a new area with adequate space.

In Pennsylvania, a similar crisis over access to prenatal care for Medicaid-eligible women occurred in Butler County. In this instance, the media publicized the crisis extensively through area newspapers. The local hospital took the lead in establishing a comprehensive program of maternity services for women whose care was covered by Medicaid in the county. The services include prenatal care; maternal and infant home visiting; coordination with other services, such as WIC, family planning, and substance abuse prevention and rehabilitation; delivery; and postpartum care. The prenatal care is provided at the hospital, with the hospital supplying all nursing, social service, clerical staff, space, and equipment. Obstetrician–gynecologists on the hospital's medical staff provide the medical services associated with the prenatal care, delivery, and postpartum care. As part of their medical staff responsibilities, physicians must participate in this program on a fair and equitable rotation basis so that the burden of providing care is divided equally among the physicians.

Arrangements can also exist between local health departments and private obstetric providers that are specifically targeted for Medicaid-eligible pregnant women. For example, in Twin Falls, Idaho, the District V Pregnancy Program uses the local hospitals, health department, private physicians, and community and migrant health centers. Women usually enter the program through the District V Health Department. When a woman receives a positive pregnancy test, she is screened for presumptive eligibility for Medicaid; if she is eligible, she receives a temporary Medicaid card, and an appointment is made with the Department of Health and Welfare where a formal determination of eligibility can be made. At the same time, two other appointments are also arranged, one with a public health nurse and the other with either a private physician or a physician in the hospital prenatal clinic. In addition to her regular appointments for medical services, the woman also receives ancillary services at the health department on a monthly basis, including a visit with her assigned public health nurse, a nutritionist, dental hygienist, and social worker. She also attends WIC class and receives WIC vouchers. According to the health department staff, the program is working well and the number of drop-in deliveries to the local hospital has dramatically decreased. With the recent increases in Medicaid reimbursement for obstetric providers, more private providers have agreed to participate in the program.

Obstetric providers may also choose to care for pregnant Medicaid-eligible women in their private offices on a rotating basis. For example, in Greenville, South Carolina, the director of obstetrics at Greenville Memorial Hospital, who also directs the hospital's prenatal care

clinic, led an effort to increase access to maternity services for Medicaid-eligible women in Greenville County. This teaching hospital has a prenatal clinic for low-income pregnant women that is capable of handling 1,200–1,400 patients, but an additional 400–500 were in need of care. Through combined effort, the hospital, South Carolina Medicaid, and the South Carolina Department of Health and Environmental Control (DHEC) successfully implemented the Prenatal Access Program. The hospital assists pregnant women with the Medicaid eligibility process, conducts a risk assessment, and assigns each woman with a case manager supplied through the local health department or hospital. Women at low risk for pregnancy complications and those who are felt to be good candidates for private care are referred to private obstetrician–gynecologists and family physicians in the community on a rotating basis. The ob/gyn manager with the South Carolina Medicaid Program assists the private physicians with any billing problems or questions they have with Medicaid. In addition, DHEC has agreed to reimburse the physicians if for some reason a pregnant woman is not eligible for Medicaid after she has been referred to a private physician. In the first 6 months, more than 250 patients have been allocated to private care. Six obstetric group practices, a total of 22 physicians, participate on a rotational basis, and the private obstetric community has been very impressed with the program.

### Task Forces, Coalitions, and Communication with Medical Societies

One strategy states use to examine the problems of infant mortality, access to perinatal care, and provider participation in Medicaid, is to establish task forces and coalitions. Task forces may be established through a state legislature or other governmental entity to study a particular issue and make recommendations. Coalitions, on the other hand, are composed of individuals or organizations who have come together in order to achieve a common goal. One strength of coalitions lies in the diversity of organizations represented. Often groups generally not associated with one another will band together in order to solve a common problem. It is not unusual for groups with diverse interests to compromise on less important issues when working in a coalition in order to achieve a shared goal. Some task forces and coalitions form in response to a single issue and disband once a solution to a problem or common goal is achieved. Others may continue tackling problems of mutual concern for longer periods. It is important to realize that state and county medical and specialty societies are often key players in local coalitions, especially in regard to legislative and regulatory activities affecting physician providers. Moreover, representatives from state medical or specialty societies may be asked by their state Medicaid agency to participate in committees on a regular basis in order to keep the channels of communication open between the state Medicaid agency and the provider community. Such efforts generally fall into three categories.

#### *Perinatal/Access Task Forces and Coalitions*

These are generally concerned with addressing the problem of infant mortality and access to maternity services for pregnant women and may not limit their focus to Medicaid alone. The Louisiana Coalition for Maternal and Infant Health has been established to improve maternal health and reduce infant mortality and morbidity in the state. In Montana, the governor established an Interagency Task Force comprising members from the state departments of Social and Rehabilitative Services; Health and Environmental Sciences; Family Services; Institutions; Labor and Industry; and the Office of Public Instruction. The purpose of the task force is to increase efficiency, reduce duplication, and promote interagency sharing of resources to improve services to low-income mothers and children. In March 1990, the Maternal and Child Health subcommittee of the task force identified improved access to obstetrical providers as a priority issue and made several recommendations, including to increase Medicaid reimbursement for delivery services (eventually to 90% of the average customary charge for the service) and for the state legislature to consider options to reduce the medical malpractice insurance costs.

In October 1990, the Oklahoma Perinatal Association, for their fall business and educational symposium, presented a program titled "Making Medicaid a User Friendly System." Some of the topics addressed included the current status of Medicaid in Oklahoma, MCH/Medicaid Partnerships for improving perinatal health, and barriers to professional participation in Medicaid from the perspective of the provider. Those attending the meeting also participated in small sessions, which developed recommendations for strengthening the Medicaid program in Oklahoma.

In Washington, a coalition initiated by two ACOG Fellows, was successful in helping to pass the Maternity Access Act of 1989, which expanded Medicaid eligibility and services under Medicaid for pregnant women, and increased reimbursement for obstetric providers. This legislation required the Department of Social and Health Services to determine which counties in the state were "maternity access to care distressed counties." Twenty-two of the thirty-nine counties were identified as distressed. Each was required to develop a countywide plan to meet immediate and emerging needs for maternity patients. Community representatives, including public health officials, community service offices, physicians, hospitals, nonprofit agencies, and community clinics developed strategies to ensure access to maternity care. Consultation by the Department of Social and Health Services was available, and used by all counties in preparing their reports. The reports specified county responses necessary to meet needs and outlined recommendations for obtaining additional funding under the state's Medicaid program.

South Carolina has implemented a similar initiative by targeting counties with high infant mortality rates. The South Carolina Partnership for Healthy Generations is funded through a 4-year federal grant with the purpose of gaining local public and private community involvement to identify and find solutions to barriers to prenatal care. The initiative targets those counties that have the greatest share of the state's infant mortality rates. Each targeted county has established an Infant Mortality Task Force composed of members from the Department of Health, the Medicaid agency, and the business and health community who meet and devise strategies to combat infant mortality in their county. According to the State Department of Health, this is a better approach than for the state to establish mandates that may not be appropriate for a particular community. As plans are being developed, the Medicaid agency offers technical and funding assistance to each county. Efforts are also made to ensure coordinated systems of perinatal care using existing resources, when possible.

*Medicaid–Provider Participation Task Forces*

Some states have established task forces to examine the problem of physician participation in Medicaid. For example, in Alabama, the Physicians Task Force was created by the Medicaid agency in order to obtain input from physicians around the state concerning possible initiatives that the Medicaid agency might consider to enhance its relationship with providers. The task force is composed of 26 physicians representing various provider specialties and the director of the Medical Association of Alabama. The task force first identified physician concerns regarding Medicaid. These issues fell into five major categories, and subcommittees were formed consisting of physicians and Medicaid agency staff to discuss and research issues in the following areas: eligibility certification and recipient benefit information; coding, audit process, and documentation; coverage issues and reimbursement; claims processing; and communication, provider education, and physician recruitment. In Missouri, a Physicians Task Force was initiated by the Medicaid agency to try address the problems with Medicaid that physicians had identified. The first priority of the physicians was a fee increase for obstetric procedures. A subcommittee of obstetricians–gynecologists was appointed to work out the details of this increase. Finally, in New Hampshire a provider participation task force, formed as a result of a state legislation, has issued a preliminary report. It discusses the reasons for low provider participation in the Medicaid program and provides recommendations for improving provider participation through increasing

reimbursement, simplifying billing procedures, limiting the effect of malpractice costs, and organized provider recruitment (35).

*ACOG, State Medical Association, and Medicaid*

ACOG and various state medical societies have also taken the lead in establishing committees to examine access to maternity care and physician participation in Medicaid. The ACOG Committee on Healthcare for Underserved Women, mentioned in the introduction, examines issues of access to care for low-income women on a national level. On the ACOG district and section levels, California, New York, Indiana, and New Mexico have similar committees. In Indiana, the ACOG section also participated in a statewide broadcast that brought obstetrician–gynecologists, Medicaid staff, and the Department of Health together on one panel to discuss the role each can play in reducing infant mortality. This broadcast was televised across the state to medical professionals. A list of ACOG district and section contacts appear in Appendix Q.

The South Carolina Medicaid agency publishes articles in the *Journal of the South Carolina Medical Association* and has taken a resolution to the state medical society regarding access to obstetric care. In Texas, the state Medicaid agency also works with the Texas Medical Association (TMA) by publishing articles in the TMA newsletter and participating as an exhibitor with an information booth at the annual convention. TMA is assisting Medicaid in developing a marketing flyer for physicians. In June 1990, the Medical Society of the District of Columbia convened a special meeting of their ob/gyn and pediatric sections to offer suggestions for recruiting and retaining physicians in the District of Columbia Medicaid program. The Medical Society of the District of Columbia (MSDC) obstetrician–gynecologists recommended the following: reduce the paperwork required for providers to submit Medicaid claims; initiate a global fee for obstetric care with rates consistent with reimbursement of at least 80% of the current rate in the community; educate practioners on the concept of continuous eligibility; and introduce an incentive program, such as monetary awards, for women seeking early and continuous prenatal care. Recommendations to address obstetrician–gynecologists' concerns over the liability situation included additional reimbursement to cover malpractice insurance costs based on a provider's malpractice insurance costs and level of participation in Medicaid, an indemnification program for obstetrician–gynecologists accepting Medicaid patients, and subsidies for a portion of an obstetrician's malpractice premium based upon the number of Medicaid babies delivered. All of the recommendations were endorsed by the MSDC Executive Board and forwarded to the Medicaid Director of the District of Columbia (36). In New Mexico, the state worked with the New Mexico Medical Society's Liaison Committee to the Human Services Department to develop a survey to document access for obstetric services for Medicaid patients. In Florida, representatives from the state Medicaid agency attend and set up information booths at professional medical association conferences and place articles in medical journals. In addition, the state Medicaid agency has undertaken a direct-mail marketing project, sending all licensed (but not Medicaid-enrolled) physicians a recruitment brochure and business reply card with letters of support from the Florida Medical Association and the Florida Osteopathic Medical Association.

## CONCLUSIONS AND RECOMMENDATIONS

This document provides descriptions of many activities initiated by state Medicaid agencies and other organizations that are working to retain and recruit obstetric providers in the Medicaid program. The concern, the creativity, the determination, and in many cases, the successes of the various efforts are encouraging. Although not exhaustive in scope, it is hoped that the state initiatives highlighted in this document will spark interest among Medicaid agency staff and other individuals in other states concerned with increasing provider participation in Medicaid. If a particular initiative shows promise or could be adapted in another state, the appropriate individual can be contacted for additional information.

There are many lessons that can be learned from the initiatives described within these pages, but perhaps one is most evident by its absence: the actual measurement of the effects of these initiatives on recruiting and retaining obstetric providers in Medicaid. Clearly, many of the initiatives described are too new to have generated an appropriate amount of data by which to evaluate their effectiveness. More importantly, many states do not have a mechanism in place to evaluate whether provider participation actually improves. Part of the problem states face in evaluating the effectiveness of various initiatives arises from the difficulties state Medicaid agencies have encountered in the definition and measurement of "participating providers," as described in the first part of this document. It is important that each state Medicaid agency reach a clear definition of a participating provider and that this definition is consistent with federal requirements. Furthermore, clear guidance is needed from HCFA not only on a standard definition of participation, but also on how to resolve the discrepancy between the definition states may be using to generate reports from their MMIS and the definition used in the HCFA guidance required by OBRA-1989 for documentation of access to obstetrical services. Finally, without a standard definition of a participating provider, it is difficult to compare the effectiveness of any initiatives to increase provider participation between states.

Each Medicaid agency must then establish the necessary mechanisms to measure the involvement of physicians and other providers in their programs. In many cases, this will involve work with other data systems within the state, such as licensure data, and with the professional groups representing the providers, such as the local gynecologic society, ACOG district or section, or the state medical society. Without an accurate baseline measurement of the number of providers already enrolled, the number available to be enrolled, and the restrictions providers place on accepting Medicaid patients, the state cannot set realistic goals for the improvement of participation problems. In order to address some of these problems, current research by the National Governors' Association under its series "Facilitating Improvement of State Programs for Pregnant Women and Children," will explore technical measurement issues and provide state Medicaid agencies with information on methods they can use to carry out measurements.

It is important to determine realistic goals for initiatives that are designed to increase participation. While many would like to see full participation—that is, obstetric providers placing no restriction upon the number of Medicaid-funded obstetric patients that will be accepted into their practices—it may be far more realistic to accomplish an organized system that distributes Medicaid-funded patients among the obstetric providers within the community in a fair share fashion, as do the programs in Greenville, South Carolina and San Diego, California. Often states have set no specific, measurable goals, and any increase in participation is perceived as an improvement. Additionally, the goals are often not known to

the very community to which they are targeted: the obstetric providers. Further complicating these considerations is the need to relate the measures of physician participation to the question of whether women who have their obstetric care paid for by Medicaid have equal access to services as women with private insurance. Even if states can make them, measurements do not necessarily answer questions about access. Finally, the goals and subsequent plans focus almost exclusively upon obstetrician–gynecologists, excluding the necessary components of family physicians and certified nurse–midwives. All these issues must be addressed.

The initiatives in this document offer positive recommendations for state Medicaid agency staff and other interested individuals concerned with recruiting and retaining providers in the Medicaid program:

**Reimbursement rates must be *adequate*. In many cases, this may not mean as high as those of other insurance programs, but high enough to cover a provider's overhead costs, including professional liability.** States such as New York have seen the positive response of obstetric providers to increases in reimbursement rates. Other states, such as California, Idaho, New Hampshire, and West Virginia, believe that increased reimbursement will produce the desired results.

**States must be willing to examine the specific problems obstetric providers encounter in the broad area of administrative issues.** After the specific problems are identified, initiatives are needed to address these problems. Responses to changes in the billing process indicate that adequate reimbursement rates are a necessary, but not sufficient, condition for Medicaid participation. If the Medicaid program introduces too many other barriers—difficulty determining if a particular patient is eligible, unreasonable restriction on the types of services covered, extensive delays in paying claims, unwieldy claim processing—these can do as much to discourage participation as low reimbursement rates. But these are solvable problems, and when solved, provide additional benefits for the Medicaid agency itself. However, it must be stressed repeatedly that until the *specific* reasons obstetric providers cite under administrative issues are identified, it will be difficult to address this broad barrier.

**Professional liability problems that restrict access for all obstetric patients, not just those whose maternity care is financed by Medicaid, need to be solved.** The initiatives described in this document show that states can solve some of this problem by indemnifying providers and providing subsidies to providers in certain geographic areas where access for maternity services is a problem for patients.

**Issues that concern providers regarding the relationship between the Medicaid patient and the provider must be addressed.** Medicaid agencies can implement initiatives to improve the problems physicians cite, such as eligibility expansions, presumptive and continuous eligibility, case management, and enhanced services. However, state Medicaid agencies must make providers aware of the expansions and services in a timely manner. MCH programs can also play an important role in delivering obstetric services to Medicaid-eligible women. The possibility of breaking the connection between welfare and Medicaid should also be explored in order to assess how the association affects a provider's decision to participate in the program. Furthermore, initiatives to address provider concerns in issues of patient compliance, culture, and language need to be developed, perhaps though patient education materials that communicate more effectively to the patient her responsibility in obstetric care.

**Improving the relationship between the Medicaid agency and the provider encourages participation, and such efforts should be continued.** Those states that have increased their provider relations activities for obstetric providers have seen a positive response from providers in both recruitment and retention. States that have established task forces or

committees that include providers in the development of the solutions to the Medicaid agency's problems—for example, Alabama, New York, Indiana, and New Mexico—find greater support for the program in the provider community because of these efforts. Finally, the role of both the state medical society and state specialty organization should be further investigated by Medicaid agencies for increasing provider participation.

Clearly, great strides have been made through eligibility expansions and other program reforms to increase access to maternity services for Medicaid-eligible pregnant women. However, without continued participation in the program by obstetric providers, the benefits of these expansions cannot fully be realized. It is the hope that this document will encourage states to attempt new initiatives, and to continue to share information on the initiatives that they are implementing to increase obstetric provider participation in the Medicaid program.

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# APPENDIXES

## APPENDIX A

## CHARGE TO ACOG COMMITTEES ON HEALTH CARE FOR UNDERSERVED WOMEN

### The American College of Obstetricians and Gynecologists

In July 1985, ACOG's President William T. Mixson appointed a Task Force on Medically Underserved Women. The concerns giving rise to this action were three: 1) For a variety of reasons, significant numbers of women are not receiving adequate obstetrical care; 2) Participation by obstetrician–gynecologists in Medicaid programs is low in many states; 3) Adolescent pregnancies continue to contribute significantly to poor perinatal outcomes.

The task force was unusual in that it was composed of members of ACOG's Executive Board, and thus could provide an immediate focus on these problems at a highly visible level within the College. The task force met twice during the summer and fall to recommend a structure through which the College could address these issues. As a result, the Executive Board has authorized the establishment of two permanent committees, which are now being appointed. The two committees will work together, with the chair of the Committee on Adolescent Health Care serving also as a member of the other committee. The 1985 task force developed, and the Executive Board subsequently ratified, a combined charge for the two new committees as follows:

### Committee On Health Care for Underserved Women
### and
### Committee on Adolescent Health Care

To delineate the problem of obstetric–gynecologic health care for underserved women and to develop and implement plans for ACOG involvement with this issue.

To focus attention on underserved women as defined roughly by the following population characteristics:

a) Those eligible for Medicaid
b) The medically uninsured and underinsured
c) Adolescents of all socioeconomic levels
d) Other populations with identified problems of access, for example, some elderly women, undocumented aliens, the handicapped, and those in rural or remote areas

To emphasize the preeminence of quality prenatal care integrated with delivery services for women in these population groups, and to stress the pivotal role of services to prevent unintended pregnancies.

To seek for ACOG a leadership role in data collection and analysis. ACOG should initiate studies independently and in cooperation with other organizations. External funding should be sought for specific projects as needed.

To concentrate on activities that would specifically improve College participation in expanding services to these groups and making the services more effective, efficient, and accessible.

February 1986

## APPENDIX B

acog **statement of policy**
AS ISSUED BY THE EXECUTIVE BOARD OF ACOG

### ACCESS TO WOMEN'S HEALTH CARE

Excellence in women's health care is an essential element of the long-term physical, intellectual, social and economic well-being of any society. It is a basic determinant of the health of future generations.

The American College of Obstetricians and Gynecologists (ACOG) is the representative organization of physicians who are qualified specialists in providing health services unique to women. ACOG calls for quality health care appropriate to every woman's needs throughout her life and for assuring that a full array of clinical services be available to women without costly delays or the imposition of geographic, financial, attitudinal or legal barriers.

The College and its membership are committed to facilitating both access to and quality of women's health care. Fellows should exercise their responsibility to improve the health status of women and their offspring both in the traditional patient-physician relationships and by working within their community and at the state and national levels to assure access to high-quality programs meeting the health needs of all women.

Approved by the Executive Board
July, 1988

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th STREET, SW • WASHINGTON, DC 20024-2188 • (202) 638-5577

# APPENDIX C

## From the Health Care Financing Administration

**Maternal and Infant Health Initiative:** The Health Care Financing Administration (HCFA) and state Medicaid agencies have placed a new focus on the nation's problem of infant mortality and morbidity. Through the Maternal and Infant Health Initiative, the HCFA and states hope to reverse the current situation: 10 of every 1000 babies born in this country die at birth; nearly 40 000 low–birth weight babies are born annually; and the cost of this infant morbidity is as much as $3 billion annually.

As a major source for financing the health care of low-income pregnant women, who are most at risk, Medicaid already offers services that make a difference in pregnancy outcomes. But more help is needed.

With this in mind, the HCFA continues to seek ways to improve Medicaid coverage and services for pregnant women and infants, a position that also reflects the priorities of the president, Congress, and the secretary of Health and Human Services. In fact, the bill submitted to Congress by the administration, "Medicaid, Pregnant Women, Infants, and Children Amendments (S 902 and HR 2216)," calls for Medicaid coverage of pregnant women and infants up to 130% of the federal poverty level, simplification of Medicaid eligibility requirements to allow for early access to prenatal care and immunizations, and outreach programs to better inform disadvantaged pregnant women of available programs.

Obviously, cooperation between all involved factions is essential for this initiative. Medicaid itself is a cooperative effort. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid programs are designed and administered by the states within broad federal guidelines. The states provide medical assistance to disadvantaged pregnant women and infants, children, and families with dependent children, and aged, blind, and disabled persons whose incomes and resources are insufficient to meet costs of necessary medical care.

The federal government, in turn, provides the states with approximately 55% of the allowable costs of the program. To launch the Maternal and Infant Health Initiative, the HCFA set up a task force that includes representatives from (1) the HCFA, (2) the US Public Health Service, and (3) the Department of Agriculture's Women, Infants and Children's program. The task force works with a technical advisory group from the state Medicaid Directors Association that, in turn, works with a similar group from the Association of State Maternal and Child Health Programs. Through these combined efforts, the task force gathers information that its members can pass along to their individual components.

The HCFA's regional offices have first-line responsibility for implementation of the initiative. With their counterparts in other federal and state agencies, they help states identify and, if possible, resolve problems in provider participation, coverage of benefits, eligibility, and outreach. They also help to coordinate programs offered by state agencies and private groups.

We encourage state Medicaid agencies to develop cooperative working relationships with physicians and with other public and private health programs, such as community and migrant health centers, family planning agencies, the Women, Infants, and Children's program, and various substance abuse treatment programs. While there is no list of "approved" activities or services, cooperating agencies can pool information about approaches that have proved successful in reaching pregnant women. They can share information about available services such as screening and treatment services, health education and counseling, case management, and transportation services.

We endorse multiple outreach strategies. For example, we recommend community campaigns to make people aware of the need for prenatal care, to encourage former Medicaid recipients to recommend other disadvantaged pregnant women they may know to seek prenatal care, and to direct outreach to places where eligible pregnant women might go (eg, church groups, adolescent clinics in shopping malls). We must make special efforts to target those pregnant women who are most difficult to reach and motivate: adolescents and alcohol and other drug abusers.

We support state-initiated program innovations. Recent legislation and administrative changes have made it possible in some cases to overcome uncertainty about a patient's Medicaid eligibility. For example, some states encourage qualified providers to presume Medicaid eligibility based on preliminary information about family income, thus allowing pregnant women immediate access to prenatal care.

Other states now guarantee payment for continuous care of eligible women throughout the pregnancy and postpartum period despite changes in family income. Some states have raised fee structures or added incentives to successfully enhance physician participation; still other states have found that merely simplifying the claims payments procedure or streamlining the eligibility process has made a difference.

To fully address relevant issues—such as alternative providers (certified nurse-midwives, nurse practitioners, clinics, etc)—it is necessary to involve obstetric and pediatric communities, medical schools, and professional societies. As part of this endeavor, we encourage states to apply "ombudsmen" approaches to provider relations. In fact, as part of Medicaid program administration, federal financial participation is available for activities related to ensuring sufficient providers.

All of these activities raise the question: If demand for prenatal care increases as a result of more Medicaid-eligible pregnant women, will supply be able to meet demand? We believe the answer is yes because our goal includes recruiting and retaining more obstetric and pediatric providers.

Not only do we encourage states to seek physician involvement in this important initiative, but we at the federal level also urge physicians to become involved. We recognize that physicians are in key positions to help low-income pregnant women receive Medicaid services.

Where language and cultural barriers exist, physicians can be instrumental in helping the disadvantaged population find the medical care it so obviously needs. We invite all physicians to help their states design and implement Medicaid program strategies that will reduce infant mortality and morbidity and improve child health.

Surely, you have suggestions for improving the availability of medical services for these needy Americans. Give us your input; we are ready to listen.

—by Louis B. Hays
Acting Administrator
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## APPENDIX E

### ACOG MEDICAID QUESTIONNAIRE ON PROVIDER PARTICIPATION

1. Do you consider provider participation for maternity services to be a problem in your state? If so, how is it a problem?

2. How does your state define provider participation? Does your state measure provider participation? If so, how? (Please be as specific as possible.) Approximately what does it cost to measure participation? Is your state coming up with any new ways to measure provider participation?

3. What do you consider the major barriers to provider participation in your state (eg, reimbursement, claims processing, excessive paperwork, liability, client problems)? Please be as specific as possible. What initiatives has your state implemented to remove any of these barriers? Have you measured the effectiveness of these initiatives? How do you measure the effectiveness? What does it cost the state to implement these initiatives?

4. Has your state Medicaid agency worked with the State Medical Society or ACOG section in terms of provider recruitment or retention?

5. What is the fee structure for maternity services in your state? Does your state reimburse family physicians and certified nurse midwives at the same rate as obstetricians? Will your state reimburse more than one provider for rendering services to the same patient?

6. How does your state enroll providers? How are providers assigned numbers? Can you distinguish between type of provider (eg, obstetrician, family physician, certified nurse midwife) and/or type of practice (eg, solo, group, health department) by the number? Are service delivery systems with more than one provider assigned multiple numbers of just one number?

7. What claim form does your state use? What information about the provider can be identified from the claim form?

8. What is the claims payment procedure like in your state? Approximately how long does it take to get paid? Does your state use a fiscal agent? Who is the fiscal agent? What is the role of the fiscal agent (eg, strictly claims payment or a provider relations/recruitment component)? Do the fiscal agent and Medicaid agency communicate about provider concerns?

9. What edits and audits are available in your state's MMIS that are applicable to maternity services?

10. What are some of the funding problems your state is facing (eg, deficits) with regard to Medicaid?

11. What solutions would you like to see implemented that would require changes in federal/state law or regulation to increase provider participation in Medicaid.

12. Are there other people to whom I should speak?

## APPENDIX F

## LIST OF STATES INTERVIEWED

**States Interviewed (41)**

Alabama
Alaska
Arkansas
Arizona
California
Colorado
Delaware
Florida
Iowa
Idaho
Indiana
Kansas
Kentucky
Louisiana
Michigan
Maryland
Missouri
Minnesota
Missippi
Montana
North Carolina
Nebraska
North Dakota
New Jersey
New Mexico
New Hampshire
Nevada
New York
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Texas
Utah
Vermont
Washington
Wisconsin
West Virginia
Wyoming

**States Not Reached (8)**

District of Columbia
Georgia
Hawaii
Illinois
Maine
Massachusetts
Rhode Island
Tennessee

**States Declining (1)**

Connecticut

APPENDIX G

# Ob/Gyn Services for Indigent Women:

## *Issues Raised by an ACOG Survey*

In 1985, the Executive Board of the American College of Obstetricians and Gynecologists created a standing Committee on Health Care for Underserved Women, asking this group to examine the issues of access to care and to develop and implement plans for the involvement of ACOG and its Fellows in solutions to the problems. The committee was instructed to concentrate on activities that would improve College participation in ensuring access by underserved women to effective, efficient, and quality care.

The committee decided that it was critical to both the understanding and solution of the problems to determine the attitudes and perceptions of practicing obstetrician–gynecologists. Consequently, as one of its first tasks, the committee surveyed the Fellowship to ascertain what services Fellows were providing to Medicaid patients and other low-income women. The survey also sought to determine what problems Fellows perceived as major obstacles in the provision of such services and what access problems are encountered by the women in their communities.

This report summarizes some of the findings from that survey and presents issues and recommendations from the Committee on Health Care for Underserved Women. The results of the survey indicate that, despite the fact that obstetrician–gynecologists feel there are significant problems with the Medicaid program, 63% of those who include obstetrics in their practice provide these services to Medicaid patients. The survey also indicates that significant opportunities exist within the ob-gyn community to increase access to services.

## METHODOLOGY

A mail questionnaire reviewed by the committee was distributed to a random sample of ACOG Fellows, chosen to ensure adequate representation of the nine ACOG geographic districts. Junior Fellows in their first 4 years of residency, military personnel, Fellows not in active practice, and those residing outside the 50 states and the District of Columbia were excluded. A total of 5,377 questionnaires were distributed, with 2,443 responses, a response rate of 45.4%. Data were tabulated and weighted to balance returns to the population proportions of each district.

## SURVEY RESULTS

### DEMOGRAPHICS

Most of the respondents were male (85.5%) and between the ages of 35–59 (Table 1). Seventy-seven percent practiced in communities of 50,001 or greater and only 23% in smaller communities. Eighty-four percent of the respondents were in a fee-for-service practice. This response group increased to 94% for those practicing in smaller communities. Younger ob-gyns were more likely to practice as salaried employees. These demographic characteristics generally correspond with the distribution of the Fellowship in other recent surveys (1).

**TABLE 1.** Demographic Characteristics of Respondents

| Characteristic | Percentage |
|---|---|
| Age | |
| Under 35 | 13 |
| 35–39 | 18 |
| 40–44 | 16 |
| 45–49 | 13 |
| 50–54 | 15 |
| 55–59 | 12 |
| 60–64 | 8 |
| 65 + | 4 |
| Sex | |
| Male | 86 |
| Female | 14 |
| Community size | |
| 50,000 or less | 23 |
| 50,001–500,000 | 43 |
| Over 500,000 | 34 |
| Type of practice | |
| Fee for service | |
| Solo | 38 |
| Single-specialty group | 38 |
| Multispecialty group | 8 |
| Salaried employee | |
| HMO, hospital community health center, etc | 11 |
| Fee for service | 3 |

**Committee on Health Care for Underserved Women**
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## GYNECOLOGIC SERVICES TO MEDICAID PATIENTS

Slightly more than half (55%) of all ob-gyns reported providing at least one gynecologic service to Medicaid patients (Table 2). Physicians in smaller communities were more likely to provide gynecologic services to Medicaid patients, as were those in multispecialty groups, health maintenance organizations (HMOs), and other salaried settings. Seventy-nine percent of those providing obstetric services to Medicaid patients also provide gynecologic services to this population.

**TABLE 2.** Provision of Gynecologic Services to Medicaid Patients

| Service | Percentage of All Respondents | Percentage of Those Who Provide Obstetric Services to Medicaid Patients |
|---|---|---|
| Family planning | 54 | 79 |
| Annual Pap smear and pelvic exam | 54 | 78 |
| Breast exam with referral for mammography if required | 55 | 79 |
| All these gyn services | 52 | 76 |

## SERVICES TO OBSTETRIC PATIENTS

Most (83%) of the ob-gyns surveyed indicated that they provide obstetric services. The percentage providing obstetric services declined in the older age groups. Variations by sex and practice type were minimal, but there was significant variation by community size (Table 3).

**TABLE 3.** Percentage of Ob-Gyns Providing Obstetric Services*

| Characteristic | Percentage |
|---|---|
| Age | |
| Under 35 | 95 |
| 35–39 | 92 |
| 40–44 | 92 |
| 45–49 | 89 |
| 50–54 | 81 |
| 55–59 | 74 |
| 60 + | 52 |
| Community size | |
| 50,000 or less | 89 |
| 50,001–500,000 | 83 |
| Over 500,000 | 79 |

*A total of 83% of all the ob-gyn respondents provide obstetric services.

## OBSTETRIC SERVICES TO MEDICAID PATIENTS

Nearly two-thirds (63%) of ob-gyns providing obstetric services indicated that they provide care for Medicaid patients. Eighty-seven percent of salaried physician employees of hospitals and health maintenance organizations (HMOs) and 81% of those in multispecialty groups indicated that they provide services to Medicaid patients. This figure dropped to 58% of those in solo practice and to 57% of those in single-specialty groups (Table 4). Eighty-five percent of ob-gyns in smaller communities indicated that they provide obstetric services to Medicaid patients, as compared with 52% of those in the largest cities (Table 4). The percentage of ob-gyns providing obstetric services to Medicaid patients also varied among the ACOG geographic districts, ranging from 52–84%. These differences require further analysis to identify local factors that influence practitioner participation.

The survey results indicate that ob-gyns provide obstetric services to Medicaid patients in a variety of settings (Table 5). Seventy-seven percent of the respondents provide such services in their private office, 42% provide all services on an on-call basis at a hospital, and 21% provide delivery services only on this basis. Twenty percent provide services to Medicaid patients through a residency program, and 15% do so in state, county, or local health departments.

Sixty percent of obstetricians who accept Medicaid patients indicated that they do not restrict the number of Medicaid patients admitted to their practices. Nonetheless, 44% reported that Medicaid patients made up 10% or less of their 1986 deliveries (Table 6). Less than 10% have practices with a majority of Medicaid patients, and many of these physicians work in institutional settings. Those practicing in smaller communities reported that Medicaid patients account for a higher percentage of deliveries. There are also variations in Medicaid caseload by type of practice (Table 6). The percentage of Medicaid patients in any given community during this period is not known.

**TABLE 4.** Provision of Obstetric Services to Medicaid Patients by Ob-Gyns Who Provide Any Obstetric Services

| Characteristic | Percentage Providing Ob Services |
|---|---|
| Practice type | |
| Fee for service | |
| Solo | 58 |
| Single-specialty group | 57 |
| Multispecialty group | 81 |
| Salaried employee | |
| HMO, hospital | 87 |
| Fee for service | 87 |
| Community size | |
| 50,000 or less | 85 |
| 50,001–500,000 | 60 |
| Over 500,000 | 52 |

**TABLE 5.** Site of Provision of Obstetric Services to Medicaid Patients

| Site | Percentage of Total* |
|---|---|
| Private Office | 77 |
| On-call, all services | 42 |
| On-call, delivery only | 21 |
| Residency | 20 |
| Health department | 15 |
| Community health center | 4 |
| Volunteer agency | 2 |
| Women's health | 2 |

*Total adds to more than 100%; multiple answers possible.

Regardless of the number of Medicaid patients seen in the physicians' practices, most physicians provide the full range of maternity services (prenatal care, delivery, and postpartum services). The percentage providing delivery services (98%), however, is larger than that providing prenatal care (93%) or postpartum services (93%).

**TABLE 6.** Percentage of All 1986 Deliveries Paid for by Medicaid

| | | Community Size | | | Practice Type | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Fee for Service | | | Salaried Employee | |
| Percentage of 1986 Deliveries | Percentage of Total | 50,000 or Less | 50,001–500,000 | Over 500,000 | Solo | Single-specialty Group | Multi-specialty Group | HMO Hospital | Fee for Service |
| 5% or Less | 27 | 18 | 30 | 34 | 27 | 31 | 25 | 22 | 17 |
| 6–10% | 17 | 19 | 17 | 14 | 15 | 21 | 18 | 10 | 30 |
| 11–20% | 22 | 26 | 24 | 12 | 20 | 24 | 26 | 17 | 14 |
| 21–50% | 22 | 31 | 18 | 19 | 26 | 20 | 22 | 23 | 18 |
| 51% or more | 9 | 3 | 8 | 16 | 10 | 3 | 5 | 21 | 13 |
| No response | 3 | 2 | 3 | 4 | 2 | 2 | 3 | 8 | 8 |
| Mean | 21.1 | 20.7 | 19.3 | 24.1 | 22.6 | 15.3 | 17.5 | 32.2 | 24.2 |
| Median | 15 | 15 | 13 | 10 | 15 | 10 | 15 | 20 | 10 |

## MEDICAID PARTICIPATION ISSUES: OBSTETRIC CARE

Low reimbursement was rated as a problem in providing services to Medicaid patients by almost 8 of every 10 ob-gyns participating in the Medicaid program (Table 7). Delays in payment and the denial or withdrawal of patient eligibility during the pregnancy were also reported as major problems for those who provide services.

Seven of every 10 respondents who do not participate in the Medicaid program rated low reimbursement as an important reason in their decision not to provide services to Medicaid patients. Denial of eligibility and slow payment were also cited as major reasons for not providing services.

The belief that Medicaid patients are more likely to sue was rated as a major deterrent to Medicaid participation by 41% of the obstetricians who do not provide services to Medicaid patients. Those in solo fee-for-service practices were more likely to cite this belief as an important reason for nonparticipation than were those in all other practice settings. Employees of HMOs, hospitals, or other agencies were least likely to cite this as an important factor.

A higher percentage (45%) of respondents who provide obstetric services to Medicaid patients also reported the concern that Medicaid patients are more likely to sue. Female ob-gyns providing services were less likely to rate this as an important concern than were male providers, and salaried employees of HMOs and hospitals were also less likely to rate this as an important concern.

**TABLE 7.** Medicaid Obstetric Participation Issues

| Provide Medicaid Ob Services | | Do Not Provide Medicaid Ob Services | |
|---|---|---|---|
| **Response** | **Percentage** | **Response** | **Percentage** |
| Low reimbursement | 79 | Low reimbursement | 68 |
| Slow payment | 55 | Denial of eligibility | 50 |
| Denial of eligibility | 48 | Slow payment | 45 |
| Believe will sue more | 45 | Believe will sue more | 41 |
| Different socioeconomic group than other patients | 36 | Medically too high risk | 27 |
| Medically too high risk | 34 | Different socioeconomic group than other patients | 19 |
| Patients uncooperative | 4 | Too much paperwork; too difficult to get reimbursement | 5 |
| Too much paperwork; too difficult to get reimbursement | 1 | Patients uncooperative | 3 |

## ACCESS PROBLEMS IN THE COMMUNITY

The majority of respondent ob-gyns reported that they do not think that low-income women, including Medicaid women, have difficulty obtaining obstetric and gynecologic services in their communities (Table 8).

Ob-gyns providing obstetric services to Medicaid recipients were more likely to indicate that low-income women experience problems in obtaining most services. The degree to which specific services were thought to be available varied according to the sex of the physician and the size of the community. Female physicians were more likely than were male physicians to believe that low-income women have difficulty in obtaining abortion services. Male physicians were more likely than were female physicians to identify annual exams, breast exams, and pregnancy diagnosis as difficult to obtain by low-income women. Those living in smaller communities more frequently identified abortion and gynecologic surgery, and those in larger communities more frequently identified family planning, Pap smears, annual exams, and pregnancy diagnosis, as difficult for low-income women to obtain.

**TABLE 8.** Ob-Gyn Perception of Access Problems in Their Communities

| Type of Service | Response | | |
|---|---|---|---|
| | Yes | No | Don't Know |
| Pregnancy-related services | | | |
| Abortion | 26 | 46 | 27 |
| Prenatal care | 22 | 65 | 11 |
| Pregnancy diagnosis | 11 | 76 | 11 |
| Gynecologic services | | | |
| Breast exam | 14 | 66 | 18 |
| Annual Pap smear | 13 | 75 | 12 |
| Family planning | 11 | 78 | 11 |
| Hospital Services | | | |
| Gyn surgery | 21 | 65 | 13 |
| Delivery | 13 | 76 | 9 |
| Newborn care | 12 | 73 | 14 |

## PROBLEMS OF WOMEN NOT RECEIVING ADEQUATE PRENATAL CARE

When asked what prevents women in their communities from receiving adequate prenatal care (Table 9), over half (54%) of the respondents identified financial barriers. 41% cited a woman's belief that prenatal care is not important, and 38% rated transportation difficulties as important factors. Physicians providing obstetric services to Medicaid patients rated each of these reasons as important more often than did those who do not provide such services. Female ob-gyns were more likely to rate most of these reasons as more important than were male physicians. Ob-gyns in larger communities were also more likely than were those in smaller communities to rate most of these reasons as more important.

**TABLE 9.** Ob-Gyn Perceptions of Deterrents to Adequate Prenatal Care

| Reason | Percentage |
|---|---|
| Cannot pay for prenatal care (no insurance or Medicaid) | 54 |
| Don't think prenatal care is necessary | 41 |
| Difficulties with transportation | 38 |
| Inadequate child care | 24 |
| Fear of doctors, medical exams, clinics, or hospitals | 22 |
| Don't know where to get prenatal care | 21 |
| Long waiting list for a first appointment | 21 |
| Waiting time for individual appointment is too long | 20 |
| Cannot arrange time off from work for prenatal appointments | 14 |
| Fear of arrest or deportation if illegally in this country | 10 |
| Cultural bias against male providers | 4 |

## SUGGESTIONS FOR CHANGE

When asked how the Medicaid program might be changed to improve access to services, respondents indicated factors relating to reimbursement, eligibility, and the range of services covered as most likely to make an impact. The relevant factors were rated as follows:

1. Increase reimbursement (88%)
2. Decrease paperwork required to receive reimbursement (82%)
3. Mandate continued eligibility for women through the first postpartum visit (64%)
4. Provide additional reimbursement for extra services (57%)
5. Simplify the application process for patients (56%)
6. Provide periodic payments during pregnancy (50%)

Respondents providing obstetric services to Medicaid patients indicated that a number of suggestions would be effective more often than did those not providing services, in particular, factors 1, 3, 4, and 5. Those in smaller communities felt more strongly that increasing reimbursement would be effective when compared with those in larger communities. Those in large communities were more likely to identify factors 4 and 5 as potentially more effective than were physicians in smaller communities.

Frequently mentioned strategies to improve access for low-income women not eligible for Medicaid included the following:

- Changing the eligibility standards for Medicaid to include all women who cannot afford care (67%)
- Providing funds to city and county health departments (58%)
- Providing transportation or mobile clinics (52%)
- Establishing separate clinics for adolescents (50%)
- Establishing special outreach services (49%)

Fewer respondents indicated that the placement of National Health Service Corps physicians (44%), requiring hospitals to develop programs to provide services (43%), creating medical society programs to distribute patients equitably to private physicians (36%), or requiring HMOs to provide care (35%) would be potentially effective.

Ob-gyns providing obstetric services to Medicaid patients were more strongly in favor of increasing eligibility than were those who do not provide services. Those in larger communities were more likely to support increasing eligibility and providing funds to health departments to provide services than were those in smaller communities. Female ob-gyns supported most suggestions more strongly than did males.

## ENCOURAGING THE PROVISION OF SERVICES

Those surveyed were asked, in an open-ended question, to identify what would induce them to initiate or increase services provided to underserved women. Although the response rate to this question was low, 27% of those who do not provide obstetric services to Medicaid patients indicated that increasing reimbursement to a reasonable level would encourage them to provide services, and 15% indicated that some limitation or protection against liability would have to be instituted for them to provide services. Eleven percent indicated that, if reimbursement were simplified, they would be inclined to provide services. However, 27% responded that nothing would lead them to change their practices.

Of those already providing services, 20% identified increasing reimbursement and 9% limitation of their liability or protection against liability as factors that would persuade them to increase the services provided to underserved women. At the same time, 20% responded that nothing would induce them to provide additional services to these women. Of those for whom Medicaid patients constitute 10% or less of their 1986 deliveries, 23% identified increased reimbursement, 9% protection against liability, and 7% simplifying reimbursement as factors that would cause them to increase services. Twenty-three percent responded that nothing would induce them to change their practices.

# CONCLUSIONS AND RECOMMENDATIONS

It would appear that the percentage of ob-gyns providing obstetric services to Medicaid patients has not changed a great deal over the past 10 years, despite an increase in the percentage of ob-gyns providing obstetric services to Medicaid patients noted between 1978–1984 (2). It must be noted that the methodology for this survey differs from those done previously and does not allow direct comparisons from 1984–1987.

Ob-gyns provide a significant amount of care to Medicaid patients and other low-income women but have the potential to provide even more services. The results of this survey indicate that several changes in health care delivery systems would encourage obstetricians to increase services to underserved women. The activities outlined below have a reasonable chance of increasing access to care.

## DOCUMENTING LOCAL ACCESS PROBLEMS

A number of recent reports have pointed out the difficulties that poor women (both Medicaid eligible and uninsured) face in obtaining adequate and timely prenatal care (3, 4). These studies indicate that there are barriers to care in many communities. Although the ob-gyns in this survey identified these barriers as obstacles to adequate prenatal care, it appears that many physicians are not aware that these problems may be widespread in their communities.

At the state level, ACOG sections should participate in efforts to investigate and document any local barriers to care. When access is shown to be a problem, the specific characteristics of the problem in each area should be described and given widespread dissemination to the Fellows, state medical societies, and appropriate government agencies. If there is sufficient capacity to provide care but underutilization of resources by patients, major outreach and educational efforts should be made by the appropriate agencies to encourage women to obtain prenatal care. In areas in which the needs of all women are being met, the systems for providing care should be documented and publicized for others to study.

## WORKING WITH LOCAL COALITIONS

The experiences of those Fellows, sections, and districts who have attempted to improve access to services for low-income women in their communities indicate that it is beneficial to work in coalition with other groups that are concerned about improving health care for women and children (eg, the American Academy of Pediatrics, the Children's Defense Fund, the Healthy Mothers, Healthy Babies Coalition, the Coalition of Hispanic Health and Human Service Organizations, the Junior League, the March of Dimes, the National Council of Negro Women, state perinatal associations and medical societies, and others). No organization or group can accomplish these changes alone, but together they have been able to do much.

## SOLVING THE PROBLEMS OF THE MEDICAID PROGRAM

The results of this survey indicate that certain characteristics of the Medicaid system are obstacles to the full participation of ob-gyns in providing care for Medicaid recipients. Many ob-gyns, however, continue to provide services to Medicaid patients despite the difficulties they experience. Reimbursement rates, slow payment systems, and loss of eligibility by patients are the major problems needing attention. It appears that decreasing the paperwork required to obtain reimbursement would be beneficial. In addition, states should be encouraged to improve the eligibility determination process and ensure continued Medicaid eligibility for pregnant women throughout the entire pregnancy and postpartum period.

Many of the barriers to physician participation can be removed by working with state Medicaid officials. Several states have been able to increase Medicaid reimbursement rates for obstetric services in the past few years, and some are beginning to report increased physician participation. It is hoped that these efforts will result in continuing or increased participation by obstetricians in the Medicaid program. Districts and sections are encouraged to participate in Medicaid advisory groups and to work with agencies for needed changes in the administration of the program.

The liability problem is not unique to Medicaid but exacerbates the already serious problem of physician participation. In the absence of more encompassing solutions, Medicaid programs should look for ways to share the risks and costs of liability as a means of encouraging physician participation. In communities in which Medicaid beneficiaries make up a significant portion of the patient population, dealing with the liability problem may be necessary in order to ensure the continued availability of obstetric services.

## INCREASE THE NUMBER OF PREGNANT WOMEN ELIGIBLE FOR MEDICAID

Ob-gyns responding to this survey indicated that one of the most powerful tools for increasing access for non-Medicaid women is to make them eligible for Medicaid. Approximately half of the states have implemented the option, made available in 1986, to raise the Medicaid income eligibility ceiling for pregnant women to 100% of the federal poverty level. New options now exist for states to further raise that ceiling to 185% of the federal poverty level. Enacting these options could significantly increase the number of poor pregnant women who are eligible for coverage under the state Medicaid program. Districts and sections can be instrumental in advising and encouraging state agencies and legislatures to enact these options. Participating in coalitions with other interested organizations is particularly important and effective in accomplishing this objective.

## SUPPORT FOR MATERNAL–CHILD HEALTH PROGRAMS

Maternal–child health programs (Title V and state funded) and community and migrant health centers are often located in communities in which there are no other sources of care. In addition to providing prenatal care, they are often funded to provide important ancillary services, such as social services and the Women, Infants, and Children (WIC) supplementary feeding program while relying upon the ob-gyns in the community to provide the essential medical services.

Although only 15% of the ob-gyns surveyed provide services to Medicaid patients in health departments, 58% see this as an important strategy to improve access. The active support of the medical community for adequately funded state and local health department programs and community and migrant health centers is critical. Cooperation between private physicians and public programs is important to ensure quality medical services and the coordination of delivery with prenatal care.

## CLARIFYING AND SOLVING LIABILITY ISSUES

The issues of the liability crisis and access to care are inextricably linked. Many factors related to liability affect access to care. Increases in premium costs result in an escalation of the cost of providing obstetric services. As a result, it is more difficult to provide services for women under low-reimbursement programs, such as Medicaid. In addition to the financial costs, patients perceived as being at medically high risk are avoided. A significantly higher percentage (45.4% versus 1.6%) of ob-gyns reported devoting 10% or less of their practice, and a significantly lower percentage (52.5% versus 98.4%) reported devoting 11% or more of their practice, to high-risk care in 1987 than in 1985 (1). As more ob-gyns refer high-risk patients, decreased access for Medicaid patients and other poor women may result.

In this survey, a significant percentage of respondents indicated a belief that Medicaid patients represent a greater risk of suit. This belief is a subject of considerable interest but little empirical research. ACOG's Department of Professional Liability recently commissioned a survey of hospitals on deliveries performed in 1982. The results indicate that 17.1% of the total deliveries reported by these hospitals were paid for by Medicaid, but that Medicaid-paid-for patients accounted for 24.8% of the malpractice claims resulting from these deliveries. This difference, however, is not statistically significant (5). Additional research would be useful, particularly regarding the underlying causes, if any differences are found to exist. In the absence of data confirming that Medicaid patients represent a greater liability risk, physicians are urged to continue providing services to these patients. Good risk management techniques should be used to minimize any potential risk.

ACOG should continue to work to inform the public of the significant implications of the liability problem within the specialty and its impact on access to care for the underserved.

## ROLE OF THE COLLEGE

The Committee on Health Care for Underserved Women believes that there is both a great opportunity and a responsibility for the College and its Fellows to assist the nation and our communities in solving the problems of access to care. ACOG and NAACOG represent a useful pool of expertise in the health care of women that should be utilized by state and national policy makers. ACOG must continue to work to increase the awareness of the Fellowship about the problems facing underserved women. At the federal level, ACOG must continue to work to improve programs designed to serve this population.

Many of the problems vary not only among states but also among communities. Districts and sections, in coalition with other organizations that share a concern for improving women's and children's health, are in an ideal position to evaluate needs in their own communities and to develop appropriate strategies for solutions to the access problems of underserved women. In most circumstances, legislators and agency leaders welcome input from communities experiencing problems that is based upon concern for the indigent patient rather than personal economic considerations. By working with states on the solutions to these problems, sections and districts can establish positive working relationships that assist in the solutions to other problems, such as professional liability. The problem of access to quality care for all women is both medical and social in nature, and the Fellows of ACOG can and should contribute to the solutions in both arenas.

## REFERENCES

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3. Alan Guttmacher Institute: Blessed Events and the Bottom Line: Financing Maternity Care in the United States. New York, AGI, 1987
4. US General Accounting Office: Prenatal Care: Medicaid and Uninsured Women Receive Insufficient Care. GAO/HRD-87-137. Washington DC, GAO, 1987
5. Opinion Research Corporation: Hospital Survey on Obstetric Claim Frequency by Patient Payor Category. Washington DC, ACOG, 1988

## APPENDIX H

# New York State Survey

*We understand that you are asked to respond to many surveys, but rarely will your responses be as important as they are now in the development of health care policies supportive of the needs of both doctors and pregnant women in New York. Thank you for your participation.*

1-7

**PART I. General Questions About Your Practice**

1. What is your primary medical specialty? (Check *one*)
   - ☐ 1 Obstetrics/Gynecology
   - ☐ 2 Family Practice
   - ☐ 3 General Practice
   - ☐ 4 Other (Specify):_____ 8
2. For how many years since graduation from medical school have you practiced medicine? (Write number in boxes)
   ☐☐ years 9-10
3. Have you ever provided obstetric care (prenatal and/or delivery care)?
   - ☐ 0 No *(Please stop here and return the questionnaire in the envelope provided)*
   - ☐ 1 Yes *(Continue)* 11
4. For how many years since graduation from medical school have you provided obstetric care? (Write number in boxes)
   ☐☐ years 12-13
5. Do you currently provide obstetric care?
   - ☐ 0 No *(Go to PART IV, question 26)*
   - ☐ 1 Yes *(Continue)* 14

**PART II. For Those Currently Practicing Obstetrics**

6. Does the obstetrical care include (Check all that apply)
   - ☐ 1 Prenatal care? 15
   - ☐ 1 Vaginal deliveries? 16
   - ☐ 1 Cesarean sections? 17
7. How would you *best* characterize your primary obstetric outpatient service site? (Check one only)
   - ☐ 1 Own office (solo or group)
   - ☐ 2 Voluntary not-for-profit hospital
   - ☐ 3 Proprietary for-profit hospital
   - ☐ 4 Public Hospital
   - ☐ 5 Public/Community Clinic (e.g. county health dept., community health center)
   - ☐ 6 Native American health facility
   - ☐ 7 Sheltered Facility (Prison, Intermediate Care Facility, Youth Facility, etc.)
   - ☐ 8 Other (Specify): _____ 18
8. Please give both the zip code *and* county of the site where you provide most of your outpatient obstetric care.
   **Zip code:** ☐☐☐☐☐ 19-23
   First five letters of **County:** ☐☐☐☐☐ 24-28
9. About how often do you refer prenatal patients you identify as high risk to specialists? (Check one)
   - ☐ 1 Always
   - ☐ 2 Usually
   - ☐ 3 Sometimes
   - ☐ 4 Never 29
10. Approximately how many hours do you *personally* provide prenatal care in a typical week?
    ☐☐ hours per week 30-31
11. Approximately how many delivenes did you personally perform in the past year?
    ☐☐☐ deliveries per year 32-34
12. Does your office have computerized or computer-assisted billing records?
    ☐ 0 No ☐ 1 Yes 35
13. Do you now provide supervision, back-up services, consultation, and/or standing orders for non-physician providers of obstetric care?
    - ☐ 0 No *(Go to question 15)*
    - ☐ 1 Yes*(Continue)* 36
14. Which kinds of non-physician providers are they? (Check all that apply)
    - ☐ 1 Nurse midwives 37
    - ☐ 1 Nurse practitioners 38
    - ☐ 1 Physician Assistants 39
    - ☐ 1 Other (Specify): _____ 40
15. *If you are a family physician or general practitioner,* do you have serious problems getting back-up from specialists for deliveries?
    - ☐ 0 No
    - ☐ 1 Yes
    - ☐ 2 Not applicable 41

16. If you are an obstetrician, do you now provide back-up for deliveries to one or more family physicians or general practitioners?

☐ 0 No ☐ 1 Yes ☐ 2 Not applicable 42

**PART III. Medicaid Patients**

17. Do you now provide obstetric care to women with Medicaid?

☐ 0 No *(Go to PART V, question 39)*

☐ 1 Yes *(Continue)* 43

18. Approximately what percent of the obstetric patients you now serve are Medicaid patients? (Check one only)

☐ 1 10% or less ☐ 3 26-50%

☐ 2 11-25% ☐ 4 more than 50% 44

19. Does your obstetric care to Medicaid women include (Check all that apply)

☐ 1 Prenatal care? 45

☐ 1 Vaginal deliveries? 46

☐ 1 Cesarean sections? 47

20. Where do you render obstetric care to women with Medicaid? (Check all that apply)

☐ 1 Own office (solo or group) 48

☐ 1 Voluntary not-for-profit hospital 49

☐ 1 Proprietary for-profit hospital 50

☐ 1 Public Hospital 51

☐ 1 Public/Community Clinic (e.g. county health dept., community health center) 52

☐ 1 Native American health facility 53

☐ 1 Sheltered Facility (Prison, Intermediate Care Facility, Youth Facility, etc.) 54

☐ 1 Other (Specify): _____ 55

21. Do you provide obstetric care at a site that either participated in the NY State Dept. of Health Prenatal Care Assistance Program (PCAP) (prior to Jan. 1, 1990), or was designated by the Dept. of Health as a comprehensive prenatal care service program (after Jan. 1, 1990)?

☐ 0 No

☐ 1 Yes

☐ 2 Don't know 56

22. Did the 1988 increase in Medicaid reimbursement from $550 to $1,037 for obstetric care have any effect on the numbers of women with Medicaid you serve? (Check one)

☐ 1 Decreased *(Continue)*

☐ 2 No change *(Continue)*

☐ 3 Don't know *(Go to question 24)*

☐ 4 Increased *(Go to question 24)* 57

23. If you did not increase the number of Medicaid patients you serve following the 1988 reimbursement increase, please check the column that best describes the importance of each factor listed below in explaining the lack of increase.

| | Most | Very | Some | Non. | |
|---|---|---|---|---|---|
| Did not know about the reimbursement increase | ☐ | ☐ | ☐ | ☐ | 58 |
| Reimbursement still too low | ☐ | ☐ | ☐ | ☐ | 59 |
| Other payment issues (pended claims, denials etc.) | ☐ | ☐ | ☐ | ☐ | 60 |
| Fiscal audit experience | ☐ | ☐ | ☐ | ☐ | 61 |
| Delays/ denials of patient eligibility | ☐ | ☐ | ☐ | ☐ | 62 |
| Patients too high risk | ☐ | ☐ | ☐ | ☐ | 63 |
| Liability issues | ☐ | ☐ | ☐ | ☐ | 64 |
| Too few colleagues | ☐ | ☐ | ☐ | ☐ | 65 |
| Too few Medicaid patients in the community I serve | ☐ | ☐ | ☐ | ☐ | 66 |
| Other (Specify): _____ | ☐ | ☐ | ☐ | ☐ | 67 |
| | 1 | 2 | 3 | 4 | |

24. Do you limit the number of Medicaid patients for whom you provide obstetric services?

☐ 0 No *(Go to PART V, question 39)*

☐ 1 Yes *(Continue)* 68

25. If you do limit the number of Medicaid patients, please check the column that best describes the **Importance** of each factor listed below in your decision to limit the number of Medicaid patients you serve.

| | Most | Very | Some | None | |
|---|---|---|---|---|---|
| Reimbursement still too low | ☐ | ☐ | ☐ | ☐ | 69 |
| Other payment issues (pended claims, denials etc.) | ☐ | ☐ | ☐ | ☐ | 70 |
| Fiscal audit experience | ☐ | ☐ | ☐ | ☐ | 71 |
| Delays/denials of patient eligibility | ☐ | ☐ | ☐ | ☐ | 72 |
| Patients too high risk | ☐ | ☐ | ☐ | ☐ | 73 |
| Liability issues | ☐ | ☐ | ☐ | ☐ | 74 |
| Too few colleagues | ☐ | ☐ | ☐ | ☐ | 75 |
| Other (Specify): _____ | ☐ | ☐ | ☐ | ☐ | 76 |
| | 1 | 2 | 3 | 4 | |

**PART IV. For Those Who Have Discontinued Or Interrupted Their Obstetric Practice**

26. In what year did you stop providing obstetric care?
1 9 ☐☐ 77-78

27. About how often did you refer prenatal patients you identify as high risk to specialists? (Check **one**)
☐ 1 Always ☐ 3 Sometimes
☐ 2 Usually ☐ 4 Never 79

28. Approximately how many hours did *you personally* provide prenatal care in a typical week?
☐☐ hours per week 80-81

29. Approximately how many deliveries did *you personally* perform in your last year of practice?
☐☐☐ deliveries per year 82-84

30. For each factor listed below check the box in the column that best describes the **importance** of each factor in your decision to stop providing obstetric care.

| | Most | Very | Some | None | |
|---|---|---|---|---|---|
| Excessive government regulation | ☐ | ☐ | ☐ | ☐ | 85 |
| Excessive third-party payer oversight | ☐ | ☐ | ☐ | ☐ | 86 |
| Fear of litigation | ☐ | ☐ | ☐ | ☐ | 87 |
| Insufficient patient numbers | ☐ | ☐ | ☐ | ☐ | 88 |
| Interference with office practice | ☐ | ☐ | ☐ | ☐ | 89 |
| Malpractice premiums too high | ☐ | ☐ | ☐ | ☐ | 90 |
| No obstetric hospital privileges | ☐ | ☐ | ☐ | ☐ | 91 |
| Third-party payer rates too low | ☐ | ☐ | ☐ | ☐ | 92 |
| Too few colleagues for back-up | ☐ | ☐ | ☐ | ☐ | 93 |
| Other (Specify): _____ | ☐ | ☐ | ☐ | ☐ | 94 |
| | 1 | 2 | 3 | 4 | |

31. Did you provide obstetric care to women with Medicaid ?
☐ 0 No *(Go to PART V, question 39)*
☐ 1 Yes *(Continue)* 95

32. Approximately what percent of the obstetric patients you served were Medicaid patients? (Check **one**)
☐ 1 10% or less ☐ 3 26 - 50%
☐ 2 11-25% ☐ 4 more than 50% 96

33. About how often did you refer Medicaid prenatal patients you identify as high risk to specialists? (Check **one**)
☐ 1 Always ☐ 3 Sometimes
☐ 2 Usually ☐ 4 Never 97

34. Where did you render obstetric care to women with Medicaid? (Check **all** that apply)
☐ 1 Own office (solo or group) 98
☐ 1 Voluntary not-for-profit hospital 99
☐ 1 Proprietary for-profit hospital 100
☐ 1 Public hospital 101
☐ 1 Public/Community clinic 102
☐ 1 Native American health facility 103
☐ 1 Sheltered Facility (Prison, Intermediate Care Facility, etc.) 104
☐ 1 Other (Specify):_____ 105

35. Did you provide obstetric care at a site that either participated in the NY State Dept. of Health Prenatal Care Assistance Program (PCAP) (prior to Jan. 1, 1990), or was designated by the Dept. of Health as a comprehensive prenatal care service program (after Jan. 1, 1990)?
☐ 0 No ☐ 1 Yes ☐ 2 Don't know 106

36. Would you ever consider resuming obstetric care in the future?
☐ 0 No *(Go to PART VI, question 46)*
☐ 1 Yes *(Continue)* 107

37. For each factor listed below check the box in the column that best describes the **importance** of each factor in your decision to resume providing obstetric care.

| | Most | Very | Some | None | |
|---|---|---|---|---|---|
| Ceiling on litigation awards | ☐ | ☐ | ☐ | ☐ | 108 |
| Higher third-party payer rates | ☐ | ☐ | ☐ | ☐ | 109 |
| Less government regulation | ☐ | ☐ | ☐ | ☐ | 110 |
| Less third-party payer oversight | ☐ | ☐ | ☐ | ☐ | 111 |
| Limit on cases eligible for jury trial | ☐ | ☐ | ☐ | ☐ | 112 |
| Malpractice insurance subsidy for Medicaid patient care | ☐ | ☐ | ☐ | ☐ | 113 |
| More colleagues for back-up | ☐ | ☐ | ☐ | ☐ | 114 |
| More patients for obstetrics | ☐ | ☐ | ☐ | ☐ | 115 |
| No-fault insurance for neurologically impaired infants | ☐ | ☐ | ☐ | ☐ | 116 |
| Reduction in liability premiums | ☐ | ☐ | ☐ | ☐ | 117 |
| Other (Specify):_____ | ☐ | ☐ | ☐ | ☐ | 118 |
| | 1 | 2 | 3 | 4 | |

38. In 1988, Medicaid increased reimbursement from $550 to $1,037. In 1990 women with higher incomes were added and eligibilty was guaranteed throughout pregnancy regardless of income change. Considering this, if you resumed obstetric care, would you include women eligible for Medicaid?
☐ 0 No *(Go to PART VI, question 46)*
☐ 1 Yes ☐ 2 Maybe 119

**PART V. Future Plans for Care to Obstetric Patients with Medicaid**

Starting in 1990, Medicaid expanded eligibility for pregnant women. What policy changes would influence the numbers of pregnant Medicaid patients you would care for?

| | Would Increase | Maybe Increase | No Change | |
|---|---|---|---|---|
| | 1 | 2 | 3 | |
| 39. **Liability issues** | | | | |
| Ceiling on litigation awards | ☐ | ☐ | ☐ | 120 |
| No-fault insurance for neurological cases | ☐ | ☐ | ☐ | 121 |
| More medical back-up for high-risk patients | ☐ | ☐ | ☐ | 122 |
| Subsidy of liability expenses for Medicaid care | ☐ | ☐ | ☐ | 123 |
| Other (Specify):_____ | ☐ | ☐ | ☐ | 124 |
| 40. **Billing issues** | | | | |
| Medicaid help to bill correctly | ☐ | ☐ | ☐ | 125 |
| Medicaid training in audit criteria | ☐ | ☐ | ☐ | 126 |
| Faster reimbursement | ☐ | ☐ | ☐ | 127 |
| Greater reimbursement | ☐ | ☐ | ☐ | 128 |
| Fewer delayed claims | ☐ | ☐ | ☐ | 129 |
| Improved communication with Medicaid | ☐ | ☐ | ☐ | 130 |
| Other (Specify):_____ | ☐ | ☐ | ☐ | 131 |
| 41. **Patient issues** | | | | |
| Able to limit Medicaid women I would accept | ☐ | ☐ | ☐ | 132 |
| Other (Specify):_____ | ☐ | ☐ | ☐ | 133 |

42. How many women with Medicaid do you plan to care for in the future ? (Check one)

☐ 1 Fewer
☐ 2 More
☐ 3 No change 134

43. Would you be willing to provide back-up to any of the following kinds of mid-level practitioners caring for pregnant women with Medicaid ? (Check all that apply)

☐ 1 Nurse midwives 135
☐ 1 Nurse practitioners 136
☐ 1 Physician assistants 137
☐ 1 Other (Specify):_____ 138
☐ 1 No, none of the above 139

44. Designation by the NY Dept. of Health as a Comprehensive Prenatal Care Services Provider enables certain hospitals, clinics and county health departments to obtain higher Medicaid reimbursement rates for care that includes not only clinical, but also **psychosocial, nutrition** and other services listed below. If the higher fee were available to physicians, which of the following services would you be willing to provide either yourself or through your staff to women with Medicaid? (Check all that apply)

☐ 1 Appraisal of clinical/ psychosocial/ nutritional risk 140
☐ 1 Risk reduction plans in these three areas 141
☐ 1 Coordination of care in these three areas 142
☐ 1 Referrals and follow-up in these three areas 143
☐ 1 Basic nutrition education and counseling 144
☐ 1 Intensive nutrition counseling 145
☐ 1 Basic psychosocial counseling and referral 146
☐ 1 Psychosocial support services 147
☐ 1 Assist women in obtaining Medicaid eligibility 148
☐ 1 Outreach to get women into prenatal care 149
☐ 1 Prenatal diagnostic and treatment services 150
☐ 1 Postpartum services 151
☐ 1 HIV - testing/counseling/treatment/referral 152
☐ 1 Maintain records on the above services provided 153

45. If you were willing to provide comprehensive care for higher reimbursements, which of the following mechanisms to assure quality would you be willing to accept? (Check all that apply)

☐ 1 Chart audit at your site by peer group physicians 154
☐ 1 Chart audit at your site by physicians from a nearby tertiary care hospital 155
☐ 1 Chart audit at your site by State Dept. of Health 156
☐ 1 Chart audit at your site by County Dept. of Health 157
☐ 1 Internal audit of charts you send to the state 158
☐ 1 Other (Specify):_____ 159
☐ 1 None of the above 160

**Part VI. Demographic Questions For All Respondents**

46. What is your sex? ☐ 1 Male ☐ 2 Female 161

47. What is your race/ethnicity?
☐ 1 Black ☐ 2 Asian ☐ 3 White
☐ 4 Hispanic ☐ 5 Other (Specify):_____ 162

48. What is your year of birth? 1 9 ☐ ☐ 163-164

49. Describe the area where you practice medicine?
☐ 1 Rural ☐ 2 Suburban ☐ 3 Urban

**Thank You For Your Participation.**
**Please Return the Survey in the Prepaid Envelope Enclosed.**

# APPENDIX I

**SOUTH CAROLINA**
**STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION**
**POST OFFICE BOX 8206**
**COLUMBIA, SOUTH CAROLINA 29202-8206**

January 12, 1990

**PHY 90-01**

# MEDICAID BULLETIN

TO: Maternal Care Providers

SUBJECT:
1. Obstetrical Fee Increases
2. Enhanced Rates for Additional Services
3. Sterilization Billing Procedures

1. Obstetrical Fee Increases

In an effort to encourage maternal care providers to increase their participation in the South Carolina Medicaid program, the State Health and Human Services Finance Commission (SHHSFC) has increased the reimbursement rates for the procedures listed below for dates of service on or after July 1, 1989.

| Description | Procedure Code | Reimbursement Rate | **Enhanced Procedure Code | Enhanced Rate |
|---|---|---|---|---|
| 1. Initial OB Exam | S1500 | $ 50.00 | S0110 | $100.00 |
| 2. Antepartum Exam | 59420 | $ 20.00/visit | S0112 | $25.00/visit |
| 3. Vaginal Delivery | 59410 | $700.00 | 59410 | $700.00 |
| 4. Cesarean Section | 59500 | $800.00 | 59500 | $800.00 |
| 5. Postpartum Exam | 59430 | $ 20.00* | S0114 | $25.00 |

* The 1989 Physician's Fee Schedule gives a rate of $25.00 for this code. That is a mistake. The correct rate is $20.00.

** See number 2 below.

2. Enhanced Rates for Additional Services

Maternal care providers will receive enhanced reimbursement if they are willing to perform some additional services which the SHHSFC feels would improve the newborn's chances of survival. Attached to this bulletin, you will find a document titled "**Healthy Mothers, Healthy Futures Maternity Health Education Checklist**." The document lists the services that the SHHSFC is requesting providers to perform on Medicaid patients. If you choose to bill Medicaid for the enhanced rates, you may use this checklist for documentation. Use of the checklist for documentation is completely optional. Examples of appropriate documentation without the checklist are printed in bold after each of the three enhanced procedure code descriptions.

| Description | Procedure Code | Reimbursement Rate | Additional Service to be performed & documented |
|---|---|---|---|
| A. Initial OB exam | S0110 | $ 100.00 | Referral to the Women, Infant and Children (WIC) supplemented food program and referral for any additional services available in the community and needed by the patient during pregnancy.* |

* A complete listing of available programs may be obtained through your County Health Department.

**An example of appropriate documentation without the checklist would be: "referred to WIC program".**

| | | | |
|---|---|---|---|
| B. Antepartum Exam | S0112 | $ 25.00 | Follow-up on previous referrals and telephone follow-up for missed appointments.** |

** Patients who repeatedly miss appointments should be referred to the local health department for maternal care outreach.

**An example of appropriate documentation without the checklist would be "patient receiving food supplement from WIC".**

| | | | |
|---|---|---|---|
| C. Postpartum exam | S0114 | $ 25.00 | WIC referral for mother and infant. Inclusion of some family planning and parenting education. |

**An example of appropriate documentation without the checklist would be: "referred to WIC program. Spent ____ minutes explaining family planning alternatives and giving parenting education".**

3. Sterilization Billing Procedures

As part of the continuing effort to streamline claims processing, the new OB Program Manager at the SHHSFC, Chris Ricken, will immediately begin working on an alternative system to alleviate unnecessary paper work on the part of the care provider and to shorten the turnaround time for physician payment on a consistent basis. Details of this system will be forthcoming.

If you have questions about anything in this bulletin you are encouraged to call Ms. Ricken at 253-6134. Your participation in the South Carolina Medicaid program is needed and appreciated.

Eugene A. Laurent, Ph.D.
Executive Director

EAL/pfjw
Attachment

# APPENDIX J

## MEDICAID INCOME ELIGIBILITY AND PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

| State | Pregnant Women % of Poverty | Presumptive Eligibility |
|---|---|---|
| Alabama | 133% | X |
| Alaska | 133% | |
| Arizona | 140% | |
| Arkansas | 133% | X |
| California | *185% | |
| Colorado | 133% | X |
| Connecticut | 185% | **X |
| Delaware | 133% | |
| District of Columbia | 185% | **X |
| Florida | 150% | |
| Georgia | 133% | X |
| Hawaii | *185% | X |
| Idaho | 133% | X |
| Illinois | 133% | X |
| Indiana | 133% | X |
| Iowa | 185% | X |
| Kansas | 150% | |
| Kentucky | 185% | |
| Louisiana | 133% | X |
| Maine | *185% | X |
| Maryland | 185% | X |
| Massachusetts | *185% | X |
| Michigan | 185% | |
| Minnesota | 185% | |
| Mississippi | 185% | |
| Missouri | 133% | X |
| Montana | 133% | **X |
| Nebraska | 133% | X |
| Nevada | 133% | |
| New Hampshire | 133% | |
| New Jersey | 133% | X |
| New Mexico | 133% | X |
| New York | 185% | X |
| North Carolina | 185% | X |
| North Dakota | 133% | X |
| Ohio | 133% | |
| Oklahoma | 133% | |
| Oregon | 133% | |
| Pennsylvania | 133% | X |
| Rhode Island | *185% | |
| South Carolina | 133% | |
| Tennessee | 133% | X |
| Texas | 133% | X |
| Utah | 133% | X |
| Vermont | *185% | |
| Virginia | 133% | |
| Washington | 185% | |
| West Virginia | 150% | |
| Wisconsin | 155% | X |
| Wyoming | 133% | **X |

* Indicates state-funded programs that also serve pregnant women with higher incomes.

** Indicates future implementation date.

# APPENDIX K

***MEDICAID ENHANCED PRENATAL CARE SERVICES***
***JULY, 1990***

| | CARE COORDINATION/ CASE MANAGEMENT | RISK ASSESSMENT | NUTRITIONAL COUNSELING | HEALTH EDUCATION | PSYCHOSOCIAL COUNSELING | HOME VISITING | TRANSPORTATION |
|---|---|---|---|---|---|---|---|
| Alabama | X | X | | | | X | |
| Alaska | X | X | X | | | X | |
| Arizona | | | | | | | |
| Arkansas | X | X | X | X | X | X | |
| California | X | X | X | X | X | X* | |
| Colorado | | | | | | | |
| Connecticut | | X | | X | | X | |
| Delaware | X | X | X | X | X | X | |
| DC | | | | | | | |
| Florida | | | | | | | |
| Georgia | X | X | | | | | |
| Hawaii | X* | X* | X* | X* | | | |
| Idaho | X | | X | | X | X | |
| Illinois | X | X | | | | | |
| Indiana | X* | | | | | | |
| Iowa | X | X | X | X | X | | |
| Kansas | | X | X | X | | X | |
| Kentucky | | | | | | | |
| Louisiana | X | X | | | | | |
| Maine | | | | | | | |
| Maryland | X | X | X | X | X | X | |
| Massachusetts | X | X | X | X | X | | |
| Michigan | X | X | X | X | X | X | X |
| Minnesota | X | X | X | X | X | X | |
| Mississippi | X | X | X | X | X | X | X |
| Missouri | X | X | | | | | |
| Montana | | | | | | | |
| Nebraska | | | | | | | |
| Nevada | | | | | | | |
| New Hampshire | X | X | X | X | X | X | |
| New Jersey | X | X | X | X | X | X | |
| New Mexico | X | | | | | | |
| New York | X | X | X | X | X | X | |
| North Carolina | X | X | | X | | X | |
| North Dakota | | | | | | | |
| Ohio | X | X | X | X | X | X | |
| Oklahoma | | | | | | | |
| Oregon | X | X | X | X | | X | |
| Pennsylvania | X | X | X | X | X | X | |
| Rhode Island | | | | | | | |
| South Carolina | X | X | X | | X | | |
| South Dakota | | | | | | | |
| Tennessee | X | X | | | | X | |
| Texas | | | | | | | |
| Utah | X | X | X | X | X | X | |
| Vermont | X | | | | | X | X |
| Virginia | X | X | X | X | | X | |
| Washington | X | X | X | X | X | X | X |
| West Virginia | X | | X | X | | | |
| Wisconsin | | | | | | | |
| Wyoming | | | | | | | |
| TOTAL | 33 | 30 | 24 | 23 | 18 | 24 | 4 |

* FUTURE IMPLEMENTATION DATE.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION

# APPENDIX L

## STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION
## PREGNANCY/NEWBORN RISK ASSESSMENT FORM

| 1. RECIPIENT'S/MOTHER'S NAME: | 2. RECIPIENT'S/MOTHER'S ID NUMBER: | 3. COUNTY: |
|---|---|---|
| 4. PERMANENT ADDRESS: (Number, Street, City, State, Zip Code) | | RECIPIENT PHONE NO.<br>CONTACT PHONE NO. |
| 5. PROVIDER'S NAME: | 6. PROVIDER'S ID NUMBER: | |
| 7. PROVIDER'S ADDRESS:(Number, Street, City, Zip Code) | | PROVIDER PHONE NUMBER: |

### PREGNANCY RISK ASSESSMENT

| 8. Assessment mo da yr | 9. EDC mo da yr | 10.Wks Gestation | 11. Birthdate mo da yr |
|---|---|---|---|
| | | | |

| 12. Gravida | 13. Para | 14. Preterm | 15. Abortions Spontaneous ___ Induced ___ | 16. Living |
|---|---|---|---|---|
| | | | | |

**LAST PREGNANCY—Check Box(es)**

- ☐ 17. Not Applicable; Prima Gravida
- ☐ 18. Three Consecutive Spontaneous Abortions
- ☐ 19. Fetal Death - Greater than 20 wks/Greater than 500 grams
- ☐ 20. Low Birth Weight - Less than 2,500 grams
- ☐ 21. Neonatal Death - Less than 28 days
- ☐ 22. Congenital Anomaly - Explain below
- ☐ 23. History of Incompetent Cervix
- ☐ 24. Other - Explain below

**CURRENT PREGNANCY—Check Box(es)**

- ☐ 25. RH Sensitization
- ☐ 26. Sickle Cell Anemia
- ☐ 27. Heart Disease
- ☐ 28. Hypertensive Vascular Diseaae
- ☐ 29. Diabetes Mellitus
- ☐ 30. Upper Renal Tract Disease
- ☐ 31. Multiple Gestation (twins, etc.)
- ☐ 32. Incompetent Cervix
- ☐ 33. Placenta Previa
- ☐ 34. Premature Labor
- ☐ 35. Premature Ruptured Membranes
- ☐ 36. Pre-Eclampsia
- ☐ 37. Eclampsia
- ☐ 38. Other - Explain Below
- ☐ 39. Referred To:

### NEWBORN RISK ASSESSMENT

| 40. Infant's Name | 41. Medicaid ID Number |
|---|---|
| | |

| 42. Mother's Admit. mo da yr | 43. Mother's Disch mo da yr | 44. Infant's Birthdate mo da yr | 45. Assessment mo da yr |
|---|---|---|---|
| | | | |

| 46. Birthweight Grams | 47. Wks. Gestation | 48. Hospital |
|---|---|---|
| | | |

| 49. Death mo da yr | 50. Infant's Disch/Trans mo da yr | 51. Hospital of Transfer<br>2nd Transfer |
|---|---|---|
| | | |

**CONDITIONS REQUIRING LEVEL II INTERMEDIATE CARE—Check Box(es)**

- ☐ 52. Wt. Greater than 1,500 grams but less than 2,000 grams
- ☐ 53. Nasal CPAP (Continuous Positive Airway Pressure)
- ☐ 54. Moderately Severe Superficial or Localized Infections
- ☐ 55. Uncomplicated Sepsis or Meningitis
- ☐ 56. Moderately Severe Cardio - Respiratory Problems
- ☐ 57. Moderately Severe Congenital Malformation - Explain below
- ☐ 58. Easily Controlled Seizures
- ☐ 59. Mild Hypoglycemia
- ☐ 60. Other - Explain Below

**CONDITIONS REQUIRING LEVEL III INTENSIVE CARE—Check Box(es)**

- ☐ 61. Wt. Less than 1,500 grams
- ☐ 62. Major Congenital Malformation - Explain below
- ☐ 63. Major Neonatal Surgery - Explain Below
- ☐ 64. Sepsis - Meningitis with Shock, Respiratory Failure, or Unstable Clinical Condition
- ☐ 65. Persistent Seizures
- ☐ 66. Cardio-Respiratory Problem Requiring Mechanical Ventilation or Endotracheal CPAP
- ☐ 67. Severe/Refractory Hypoglycemia
- ☐ 68 Other - Explain Below

COMMENTS / EXPLANATION

NOTE: (ATTACH ADDITIONAL DOCUMENTATION IF NECESSARY) ☐ INFANT HOME VISIT REFERRAL

SHHSFC FORM 204 (REV. JULY 89) STATE HHSFC (MEDICAID) - POST OFFICE BOX 8206 - COLUMBIA, S.C. 29202-8206

# DEFINITIONS

## LAST PREGNANCY (or past pregnancy without an intervening good outcome)

12. **Gravida.** The number of times a woman has been pregnant.

13. **Para.** The number of live or stillborn infants of more than 20 weeks gestation a woman has delivered.

14. **Preterm.** The number of infants with a gestational age of less than 38 weeks.

15. **Spontaneous Abortion.** The number of spontaneous expulsions of a nonviable fetus.

    **Induced Abortion.** The number of deliberate interruptions of a pregnancy.

16. **Living.** The number of living children.

18. **Three Consecutive Spontaneous Abortions.** Fetuses of last three pregnancies each weighed less than 500 grams [about 1 lb. 1 oz.] and/or each gestation period was less than 20 weeks.

19. **Fetal Death.** Dead fetus of last pregnancy with documented weight of greater than 500 grams [about 1 lb. 1 oz.] and gestation period was greater than 20 weeks.

20. **Low Birth Weight.** Liveborn infant of last pregnancy weighed less than 2,500 grams [about 5 lbs. 8 oz.].

21. **Neonatal Death.** Liveborn infant of last pregnancy died during the first 28 days of life.

22. **Congenital Anomaly.** Infant of last completed pregnancy had a severe life threatening congenital anomaly requiring major medical or surgical intervention.

23. **History of Incompetent Cervix.** History of miscarriage in the second trimester related to cervical incompetence or patient received antepartal treatment for incompetent cervix in a past pregnancy.

## CURRENT PREGNANCY

25. **RH Sensitization.** Rh negative patient with Rh antibodies.

26. **Sickle Cell Anemia.** Not sickle cell trait.

27. **Heart Disease.** Patient currently has organic heart disease regardless of functional classification. Provide documentation.

28. **Hypertensive Vascular Disease [HVD].** Patient has diagnosed chronic HVD as evidenced by repeated elevated blood pressure readings greater than 140/90 prior to this pregnancy or has developed hypertension without proteinuria and/or edema [see pre-eclampsia, item 36].

29. **Diabetes Mellitus.** Patient has diagnosed diabetes mellitus [includes gestational diabetes] as evidenced by altered carbohydrate metabolism. Give results of 3-hour glucose tolorance test, if ordered.

30. **Upper Renal Tract Disease.** Pathologic conditions of the kidney are present, i.e., pyelonephritis, chronic or recurrent urinary tract infections with chills, fever, back pain, or CVA tenderness. NOTE: Not signs and symptoms of cystitis.

31. **Multiple Gestation.** Twins, triplets, etc., documented by ultrasound.

32. **Incompetent Cervix.** Early effacement and/or dilatation of the cervix is present. Provide documentation if previous history of incompetent cervix is absent.

33. **Placenta Previa.** Evidence of the placenta in the lower uterine segment is verified by ultrasound in the third trimester.

34. **Premature Labor.** Progressive dilatation and effacement of the cervix occurs before 37 weeks gestation are completed.

    Level II hospitals can provide care for patients in premature labor at 33 to 36 weeks gestation and if the fetus is estimated to weigh 1500 grams or more.

    Level III hospitals can provide care regardless of weeks gestation or weight.

35. **Premature Ruptured Membranes.** Patient has evidence [fluid escaping, positive fern or nitrazine test] of ruptured membranes at less than 37 weeks gestation.

36. **Pre-eclampsia.** Patient has a blood pressure reading greater than 140/90 and/or greater than 30mm rise in systolic or greater than 15mm rise in diastolic pressure and proteinuria and/or edema is present.

37. **Eclampsia.** As evidenced by generalized convulsion or coma.

## APPENDIX M

## *PERINATAL ACCESS PROJECT*

American College of Obstetricians and Gynecologists, District IX 20
Irvine Foundation

Linda Bethel, M.P.H.
Project Coordinator

349 Cedar Street
San Diego, CA 92101-3197
(619) 231-2828

As you may know, ACOG District IX, through a grant from The James Irvine Foundation, is developing a Perinatal Access Project which is committed to improving access to prenatal care in San Diego County The goals of the project are to recruit physicians into the Medi-Cal program and to establish a Telephone Referral Service to link low income women to appropriate prenatal care The San Diego Gynecological Society voted to support this project in September 1989 by suggesting that each physician accept at least one new Medi-Cal obstetrical patient from the referral service each month.

The physicians of the Advisory Board have developed a triage system for excluding high risk patients if you so desire The patients will be referred to eligibility workers prior to the office visit in order to expedite the Medi-Cal eligibility process.

The County of San Diego Department of Health Services is developing a Perinatal Provider Network in which they will act as the fiscal intermediary and bill Medi-Cal for the physician. This intermediary will guarantee payment within thirty days of receipt of the bill. For this service they will deduct approximately 7% of the payment. The goal is to obviate the Medi-Cal bureaucracy for the physician who only sees one or two new Medi-Cal patients per month This program is in the development phase currently although the idea has been approved in concept by the County Board of Supervisors

Enclosed is an information sheet entitled "Access to Perinatal Care" that summarizes various efforts designed to impact the problem of access to prenatal care in San Diego County We urge you to indicate your interest in participating in the program by completing the "Perinatal Access Project Provider Information" form and returning it in the postpaid envelope provided. The project coordinator, Linda Bethel, will contact you if you desire further explanation regarding the program.

Thank you in advance for your participation in this program. Without your help there is no solution for this escalating problem.

Sincerely,

Josephine Von Herzen, MD

Josephine Von Herzen, MD
Vice Chairman, California Section 5, ACOG District IX

Physician Advisory Board Members:

Robert Detrich, MD
Edward Goldstein, MD
Galen Hansen, MD
Thomas Moore, MD
William Swartz, MD
W. Benson Harer, Jr., MD, Chairman, ACOG District IX

## ACCESS TO PERINATAL CARE



The following public and private sector programs are designed to improve access to perinatal care for low income women:

MEDI-CAL REIMBURSEMENT
- Rate increased to over $1000 for providing global perinatal care, with enhanced rate to over $2300 for Comprehensive Perinatal Services Program providers.
- Toll-free number to specifically address obstetric billing issues.
- Support services in the form of billing seminars and regional representative visits.

MEDI-CAL ELIGIBILITY FOR PERINATAL SERVICES
- Plan to expedite the eligibility process for all pregnant women.
- Plan for caseworkers with perinatal caseloads trained to maximize the continuous eligibility of patients throughout the perinatal period.
- Eligiblity for Medi-Cal without share of cost increased to 200% of the federal poverty level for pregnant women.
- Eligibility extended to undocumented aliens.

PERINATAL PROVIDER NETWORK (PPN)
- County of San Diego is developing a plan for public/private partnership to coordinate perinatal services within the county. When implemented this plan will, in part, allow the county to act as the fiscal intermediary for physicians, ensuring prompt payment of claims.

PRENATAL CARE GUIDANCE PROGRAM
- Identifies high risk clients.
- Assists with Medi-Cal application process.
- Refers to perinatal care, health resources and Public Health Nursing as necessary.
- Provides periodic contact throughout pregnancy.

TELEPHONE REFERRAL SERVICE
- Triage and referral to appropriate care provider.
- Assist in equitable distribution of Medi-Cal patients.
- Assist in accessing the Medi-Cal eligibility process.
- Patient education to increase compliance.
- Liaison function to identify and address problems within the system.

---

For more information contact:

Perinatal Access Project
349 Cedar Street
San Diego, CA 92101-3197

Linda Bethel
Project Coordinator
(619) 231-2828

**PERINATAL ACCESS PROJECT**
**PROVIDER INFORMATION**



Provider Name: _____
(please print)
Office Address: _____

_____ Phone: _____

Office contact person: _____

---

_____ I will participate. In lieu of a visit from the project coordinator, I will provide the following information regarding the level of my participation:

Special Requirements for Telephone Referral Service (check all that apply):

Risk Factors: _____ Low Risk _____ High Risk

Language: _____ English _____ Spanish
_____ Tagalog _____ Other (specify):

_____ I will take patient only after Medi-Cal card received.

_____ I will take patient before Medi-Cal card received.

_____ I will take an occasional patient regardless of ability to pay.

_____ I will see _____ new patients/month referred from the phone line.

_____ Hospital privileges (specify hospital): _____

_____ Other requirements (continue on back): _____

Medi-Cal provider information:

_____ I am currently a Medi-Cal provider.

_____ I would like information about becoming a Medi-Cal provider.

_____ I am a Medi-Cal provider, but would like assistance with billing issues.

_____ I would like information about the County Perinatal Provider Network.

---

_____ I would like a phone call or visit from project coordinator, Linda Bethel, to explain the program.

---

Provider Signature: _____ Date:_____

(1/31/90)

# APPENDIX N

JOHN ASHCROFT
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
P.O. BOX 6500
JEFFERSON CITY
65102-6500

June 22, 1990

Dear Doctor:

We would like to take this opportunity to encourage your participation in a Medicaid program directed towards reducing inadequate prenatal care and improving reimbursement rates for obstetrical providers.

As you know, while Missouri's infant mortality rate has dropped very slightly over the last several years, the inadequate prenatal care rate has increased substantially. Even more worrisome is the increased inadequate prenatal care rate among the Medicaid population (37.4%) as compared with Missouri women overall (17.6%).

We believe that there are two major approaches to this problem. One of these is to improve provider participation in Medicaid. The second is to improve education and incentives for women to enter prenatal care early. Specifically, this letter describes efforts by your colleagues to increase reimbursement as a method to improve provider participation in Medicaid.

The substantial improvement in reimbursement rates for obstetrical providers has occurred in our state because of the collaboration of multiple individuals and organizations. Most significantly, Governor John Ashcroft has made this recommendation as part of his Governor's initiative regarding the prevention of infant mortality. The Missouri State Legislature made a bi-partisan commitment to this issue in the recent legislative session. The Physicians Task Force of Missouri Medicaid, a group of physicians (none of whom were obstetricians) developed the increased reimbursement package, educated lawmakers regarding the significance of the package and continued to work toward its implementation. All of these individuals and agencies are acutely aware of the obstetrical provider shortage and the consequences for the mothers and infants of Missouri.

As of July 1, 1990, obstetrical reimbursement for prenatal care and delivery (at least five complete prenatal visits) will be

$1,050. The reimbursement for a vaginal delivery will be $550, for a c-section, $600. A c-section with hysterectomy will be $900. It is our hope that public and private providers, primary and tertiary care providers, will join together to maximally utilize this increased reimbursement fee. In order to compensate those obstetrical providers who provide care for women during their prenatal period, but for a variety of reasons do not deliver the patient or provide the total package of prenatal care, adjustments have been made to reimburse these providers adequately for their services.

Ideally, all Medicaid women will have one primary source for their prenatal care and delivery. However, we recognize that this is not always possible. Obstetrical providers who perform greater than or equal to five prenatal visits, but do not deliver the baby because of high risk complications, need for a cesarean section, patient relocating, etc., are eligible for a global prenatal rate of $500. Specifics about these increased reimbursement rates will be available in an upcoming Medicaid provider bulletin.

Important additional programs for Medicaid obstetrical providers include a deferred compensation program for Medicaid income and malpractice liability coverage for Medicaid providers caring for pregnant Medicaid-eligible women.

We strongly encourage you to consider becoming a Medicaid obstetrical provider. If you are currently a Medicaid provider, consider increasing the extent of your participation and encouraging other providers in your community to join with us in helping to reduce the inadequate prenatal care rate for Medicaid women in our state. Both the American College of OB/Gyn and the American Academy of Family Physicians have encouraged their members to provide care for indigent and Medicaid eligible women. We hope that with the increased reimbursement to providers and increased education for women, we will achieve together what none of us can do alone. Call us at (314) 751-3277 to discuss the new reimbursement package, hear your concerns regarding existing Medicaid policies, and open the dialogue for improved relationships with obstetrical providers. We can also provide assistance with billing problems.

Please join us in the effort to improve the health of our next generation!

Sincerely,

Coleen Kivlahan MD

Coleen Kivlahan, M.D., Chair
Physicians Task Force

Gary Stangler, Director
Department of Social Services

CK:dab

# APPENDIX O

BUDDY ROEMER
GOVERNOR

State of Louisiana
EXECUTIVE DEPARTMENT
Baton Rouge
70804-9004

POST OFFICE BOX 94004
(504) 342-7015

Date

Name
Address
City/State/Zip

Dear Dr. :

I am concerned about the high infant mortality rates in Louisiana. It is a complicated problem that affects all of us. The solution will require the government to work with the medical community.

I have taken a number of steps to address infant mortality by improving access to prenatal and postpartum care. Pregnant women whose incomes are up to 133% of poverty now qualify for Medicaid. I have increased your rates for reimbursement and have signed legislation that will provide indemnification for providers who have a caseload of ten percent or more publicly financed patients. Examples of the new rates include:

| | |
|---|---|
| Initial OB Exam | $ 50.00 |
| Vaginal Delivery | $ 760.00 |
| C-Section, Classical | $1000.00 |
| Follow-up Visits | $ 27.00 |

I want to be sure that you are aware of these changes and ask for your help. It is critical that Louisiana increase the number of obstetricians willing to accept Medicaid patients. Please consider this letter a personal invitation to participate in our program. You may call the Medicaid Program office for further information. The number is (504)342-9513.

The future of our state depends on our ability to produce healthy children. I hope you will join with me in an effort to ensure a healthy future for all of Louisiana's citizens.

With kindest regards,

Sincerely,

Buddy Roemer
Governor

BR:klf

# APPENDIX P

The American College of Obstetricians and Gynecologists

DISTRICT II • NYS

Mary Armao McCarthy
*Executive Director*

Murray L. Nusbaum, M.D.
*Medical Advisor*

152 Washington Avenue
Albany, New York 12210
(518) 436-3461

March 24, 1990

Dear ACOG Physician:

We are writing both to provide information and request your support. As you know, after several years of effort, New York State was successful this year in extending Medicaid maternity benefits to cover a greatly expanded number of women. Indeed, it is estimated that approximately one-third of all births in the state will be funded by the new program.

For those of you already serving Medicaid patients, we applaud your efforts and encourage your continued service and your input to make the new program successful.

For those of you who may not at this time be accepting Medicaid, we urge you to consider entering or re-entering the system. In fact, with the higher income eligibility for Medicaid which was effective January 1, 1990, it is increasingly likely that women already seen in a private practice may qualify for Medicaid reimbursement.

A preliminary study completed after the obstetrical Medicaid fee increase in 1988 showed an increased number of providers. Yet we need to build further on the pool of physicians to ensure adequate access to care. Towards, that end, we ask two things:

1. Please make every effort to renew your Medicaid participation now. Take the time to review the enclosed information, which explains the new program and decide the best participation option for you. Contact the Department of Social Services Bureau of Primary Care, Claire Malone, 518-473-4054, with any questions.

2. You will be contacted later this month by ACOG for your input on obstetrical service to all populations, including the particular problems in Medicaid. This survey is sponsored by ACOG District II's Committee on Underserved Women. We need your input to develop workable programs. Please respond!

Thank you for your attention and response on these issues.

John W. Schelpert III, M.D.
Chairman
ACOG, District II

Jo-Ann A. Costantino
Deputy Director
Department of Social Services

# APPENDIX Q

## ACOG DISTRICT CHAIRMEN

**DISTRICT I CHAIRMAN**
Buell A. Miller, M.D.
260 Western Avenue
South Portland, ME 04106
(207) 774-5941

**DISTRICT II CHAIRMAN**
Murray L. Nusbaum, M.D.
Professional Building
1656 Champlin Avenue
Utica, NY 13502
(315) 797-3665

**DISTRICT III CHAIRMAN**
Leopold S. Loewenberg, M.D.
1100 Walnut St., Suite 301
Philadelphia, PA 19107
(215) 955-5500

**DISTRICT IV CHAIRMAN**
William C. Andrews, M.D.
880 Kempsville Road, Suite 2200
Norfolk, VA 23502
(804) 466-6350

**DISTRICT V CHAIRMAN**
Philip N. Eskew, Jr., M.D.
13450 North Meridian, Suite 200
Carmel, IN 46032
(317) 573-7055 or (317) 872-8552

**DISTRICT VI CHAIRMAN**
George D. Wilbanks, M.D.
Rush Presby./St. Luke's Med. Ctr.
1653 West Congress Parkway
Chicago, IL 60612
(312) 942-6382

**DISTRICT VII CHAIRMAN**
Richard S. Hollis, M.D.
Physicians & Surgeons Clinic
900 South Boulevard Drive
Amory, MS 38821
(601) 256-9331

**DISTRICT VIII CHAIRMAN**
George H. Schade, M.D.
50 East Dunlap Avenue
Phoenix, AZ 85020
(602) 678-1111

**DISTRICT IX CHAIRMAN**
Roger W. Hoag, M.D.
2915 Telegraph Avenue
Berkeley, CA 94705
(415) 845-8047

**ARMED FORCES DISTRICT CHAIRMAN**
Thomas A. Klein
COL MC USA
Department of Ob/Gyn
Walter Reed Army Medical Center
Washington, DC 20307
(202) 576-1201

## ACOG SECTION CHAIRMAN

**ALABAMA SECTION CHAIRMAN**
G. William Manifold, M.D.
2114 Brookmeade Road, S.E
Decatur, AL 35601
(205) 355-9711

**ALASKA SECTION CHAIRMAN**
Lydia A. Eastburn, M.D.
3340 Providence Drive, Suite 451
Anchorage, AK 99508
(907) 562-4500

**ALBERTA SECTION CHAIRMAN**
David M. Buchanan, M.D.
14120 - 97th Avenue
Edmonton, Alberta, Canada T5N 0C9
(403) 423-1840

**ARIZONA SECTION CHAIRMAN**
Palmer C. Evans, M.D.
2308 N. Rosemont Boulevard
Tucson, AZ 85712
(602) 881-1977

**ARKANSAS SECTION CHAIRMAN**
Robert P. Young, M.D.
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